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)	
Medical Services	BH 003	Dyadic Services	The policy covers Dyadic services and dyadic caregiver services	New Policy		X		
Medical Services	BH 004	BHT Services	The policy covers behavioral health treatment (BHT) services	New Policy		X		
UM	CBAS-002	Expedited Initial Member Assessment for CBAS Eligibility	Describes the process for doing an expedited assessment for CBAS eligibility	Addition of regulatory language related to the Individual Plan of Care, clarification of which members are eligible for an expedited assessment, circumstances in which the Face to Face requirement is waived, updated definitions and references.	X			
UM	CBAS-004	Member Assignment to a CBAS Center	Policy describing the process to determine which CBAS center is most appropriate for a member, taking into considerations the member's characteristics and preferences.	Annual Update, no changes required.			X	
CLS	001	Cultural and Linguistic Services (CLS) Program Description	Describes elements of the Alliance Cultural and Linguistic Services including objectives, activities, roles, work plan and organization chart.	Yearly review, minor grammar, formatting and logo updates only.				
CLS	002	Member Advisory Committee	Describes role, function and policies for the Alliance Member Advisory Committee.	Yearly review, minor grammar, formatting and logo updates. Replaced "Member" with "Community" and "MAC" with "CAC" to align with name change to Community Advisory Committee. Also updated CAC Terms of Service and attendance to align with CAC charter updates.	x			
CLS	003	Language Assistance Services	Describes how the Alliance ensures interpreter and translation services for Alliance members who require language assistance services.	Yearly review, minor grammar, formatting and logo updates. Replaced HCQC with QIHEC. Replaced words for cultural appropriateness and appropriate program name. Updated alternative format information to align with APL. Also, spelled out acronyms.	x			
CLS	008	Member Assessment of Cultural and Linguisic needs	Describes how the Alliance monitors the language needs of members and ensures these members have access to language assistance services.	Yearly review, minor grammar, formatting and logo updates. Replaced HCQC with QIHEC. Updated policy reference to updated policy name. Added additional wording in References and Definitions/Acronyms sections.	x			
CLS	009	CLS Program - Contracted Providers	Describes how the Alliance ensures its providers are informed of their responsibilities and provide language assistance services to members.	Yearly review, minor grammar, formatting and logo updates. Replaced HCQC with QIHEC. Added "provider quarterly packets" as another modality to share interpreter services access information.	x			
CLS	010	CLS Program - Staff Training and Assessment	Describes how the Alliance ensures staff receives cultural sensitivity training and are assessed for bilingual capacity.	Yearly review, minor grammar, formatting and logo updates. Replaced HCQC with QIHEC. Added new HR policy as a reference. Added new contractual requirements/enhancements related to the cultural sensitivity training.	x			
CLS	011	CLS Program - Compliance Monitoring	Describes how the Alliance ensures quality language assistance services through monitoring of staff, providers and language services vendors.	Yearly review, minor grammar, formatting and logo updates. Replaced HCQC with QIHEC. Replaced words for cultural appropriateness. Also, replaced "MAC" with "CAC" to align with name change.	x			

CMDM	CM-001	Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment	Identify, screen, enroll and assess for CCM.				X	
CMDM	CM-004	Care Coordination of Services	Structure of Plan's Care Coordination Services	Addition of language to ensures no duplication of services information sharing processes IHSS referrals Children with Special Health Care Needs (CSHCN) Direct Observed Therapy for TB Addition of language to ensure regular communication with IHSS regarding open medical issues and related social issues. BPHM reqs.	X			
CMDM	CM-009	Enhanced Care Management - Infrastructure	Infrastructure for ECM	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-010	Enhanced Care Management - Member Idenfication and Grouping	Identifying members for ECM eligibility and assigning members to ECM providers	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-011	Enhanced Care Management - Care Management and Transitions of Care	Responsibilities of ECM providers to provide care management and transitions of care to ECM members	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-013	Enhanced Care Management - Oversight Monitoring & Controls	Oversight and monitoring process of ECM providers	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-014	Enhanced Care Management - Operations Non-Duplication	Identifying members who are receiving ECM and preventing duplication of services	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-016	Enhanced Care Management - Staffing	Expectations for staffing of ECM providers	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-018	Enhanced Care Management - Member Notification	Informing member of ECM eligibility, and determination of authorization	Update policies to be in alignment with most recent approved MOC submission (February 2023).	X			
CMDM	CM-021	Community Supports - Asthma Remediation	identify, refer, authorize for asthma remediation				X	
CMDM	CM-022	Community Supports - Housing Deposits	identify, refer, authorize for housing deposits				X	
CMDM	CM-023	Community Supports - Housing Tenancy and Sustaining Services	identify, refer, authorize for housing tenancy and sustaining services				X	
CMDM	CM-024	Community Supports - Housing Transition Navigation	identify, refer, authorize for housing transition navigation				X	

CMDM	CM-025	Community Supports - Medically Supportive Food/Meals/Medicalyl Tailored Meals	identify, refer, authorize for medically supportive food/meals/medically tailored meals				X	
CMDM	CM-026	Community Supports - Recuperative Care (Medical Respite)	identify, refer, authorize for recuperative care (medical respite)				X	
CMDM	CM-027	Community Supports - Oversight Monitoring and Controls	identify, refer, authorize for oversight monitoring and controls				X	
HED	001	Health Education Program	Descibes Alliance Health Education Program Elements	Yearly Update and minor grammar edits.			X	
HED	002	Health Edcation Materials	Describes process for creating and approving health education and member informing materials.	Yearly update and minor grammar and edits.			X	
HED	006	SABIRT Services	Describes alcohol and drug screening, assessment, brief interventions and referral to treatment benefit.	Yearly update and minor grammar and edits.			X	
HED	007	Tobacco Cessation	Describes Alliance policy on tracking tobacco use and implementing cessation services.	Yearly update and minor grammar and edits.			X	
HED	009	Diabetes Prevention Program	Describes how the Alliance offers the Diabetes Prevention Program to eligible members.	Yearly update and minor grammar and edits.			X	
LTC	LTC-001	Long Term Care Program	Describes Long Term Care program, overarching policy	Updated for ICF/DD and Subacute APLs	x		x	
LTC	LTC-002	Authorization Process and Criteria for Admission, Continued Stay, and Discharge from a Nursing Long Term Care Facility	Describes admission/Re-auth and Discharge processes in LTC	Changed owner to LTSS Director. Updated language to align with the new LTC Carve ins for S/A and ICF/DD. Removed language referencing the 21 day list. Updated regulatory references.	x		x	
LTC	LTC-004	LTC Bed Hold and Leave of Abcense	Describes procedures for Bed Holds and Leaves of Abcense for LTC populations	Updated for ICF/DD and Subacute APLs	x		x	
PHM	001	Population Health Management Program	Descibes the elements of the Alliance's Population Health Management Program in alignment with the DHCS PHM Policy Guide. Refers to Alliance policies and procedures that detail Alliance population health management elements and programs.	Updated to align with December DHCS PHM Policy Guide updates to the Population Needs Assessment (PNA) including colllaboration with Local Health Agencies, use of Quality and Key Performance Indicators to assesss programs, and added definitions.	X			
PHM	002	Basic Population Health Management	Describes Alliance Population Health Management supports including provision of BPHM services by PCPs, role of Alliance ECM, LTC and Care Management staff, Wellness and Prevention activities and refers to related P&Ps and services.	Updated EPSDT language to "Medi-Cal for Kids and Teens," added Alliance P&P references for Population Health and Disease Management, added MOU development, and removed requirement to have toll-free telephone number for network providers to align with updated DHCS Contract.	X			
PHM	005	Population Assessment	Describes how the Alliance understands and assessess its member population and subpopulations by demographics, health, utilization, SDOH and other characteristics in compliance with DHCS PHM Policy Guide and NCQA PHM requirements.	Move P&P from HED to PH, rewrote/updated to align with DHCS PHM Policy Guide, including LHJ engagement, meaningful participation in Community Health Assessments and shared goals, objectives with LHJs, engagement with the Alliance CAC.	X			
QI	124	Initial Health Appointments	Requirements around Initial Health Appointments - a comprehensive assement tht is compled during a patient's initial encounter	Changes to meet APL 22-030, updated codes and outreach requirements	X		X	

QI	125	Blood Lead	This policy and procedure outlines the process for meeting compliance with State and Federal regulations for blood lead screening and reporting requirements for Medi-Cal managed care health plans.				X	
UM	UM-002	Coordination of Care	Coordination of Care for all AAH members following the PHM policy guide for Basic Population Health Management	Collaborated with the PHM Department to update the policy to reflect the requirements in the PHM Policy Guide. This policy was sent to the state as a deliverable in March 2023. Updated formatting, removed verbaige about disenrollment for members in LTC Settings as it is no longer applicable.	x		x	
UM	UM-002	Coordination of Care	Overarching policy that describes the regulations, practices and processes to coordinate the care of members across the organization, including primary care, case management, and Population Health Management.	Addition of regulatory language regarding population health management, assessment of need and delivery of services, role of primary care, EPSDT, CCS, adherence to information sharing requirements, closed loop referrals, along with regulatory references, definitions, and grammatical corrections	X			
UM	UM-010	Coordination of Care-Long Term Care	Care Coordination to admit and discharge members appropriately into the Long-Term Care Facilities.	Changed policy name and number to an LTC Policy- LTC-005. Will Retire this policy number. Updated formatting, removed language related to Hospice admissions and disenrollment back to FFS. Added languague about ECM, Corrected verbiage on the HCBA waiver from the NF waiver langage which is outdated. Enhanced the process for TCS referrals. Updated policy and references sections.	x		x	
UM to BH	Change: UM-012 to BH-005	Care Coordination-Behavioral Health	Policy that describes the processes for coordination of care for persons with mental health or Substance Use Disorders	Transfer of policy ownership from UM department to BH department	X			
UM to BH	Change: UM-013 to BH-006	Care Coordination-Substance Abuse	Policy that describes the processes for coordination of care for persons with Substance Use Disorders	Transfer of policy ownership from UM department to BH department	X			
UM	UM-018	Targeted Case Management and Early and Periodic Screening, Diagnosis and Treatment	TCM and EPSDT	Addition of details on LGAs and information exchange with LGAs	X			
UM	UM-024	Care Coordination-Dental Services	Describe care coordination, utilization management, and oversight processes for dental services, including coordination with Dental FFS	updates made to align with revised DHCS APL 23-028, specifying requirements for IV moderate and deep sedation/general anesthesia, and other medically necessary services, when administered in connection with dental services not performed by dental providers . Minor formatting changes. Updated phone number.	x		x	
UM	UM-032	Therapeutic Enteral Formulas	Policy related to authorization and oversight of members receiving Enteral Nutrition	Formatting updates. Removed the Emergency Request. Updated ages-21 and younger is considered Pediatric per DHCS for this benefit. Added verbiage related to the deleniation between formula and supply responsbility. Expedited changed from 3 working days to 72 hours to align with timeleness standards. Removed context about WIC as it is covered in Policy UM-030 and is not applicable to members receiving enteral nutrition. Added information re: Group Care LOB Process	x		x	

UM	UM-045	Communication Services	Describes UM processes for provision of culturally and linguistically appropriate communications (including verbal, written, and alternate format communications) to members and providers	added Alternate Format communication requirements per DHCS APL 22-002	X			
UM	UM-050	Tracking and Monitoring of Services Prior Authorized	This policy describes the methods by which AAH monitors the services that have been authorized prior to care, including those for whom AAH has not received a claim, and the follow up to prompt members to obtain the authorized care.	Annual Update, no changes required.			X	
UM	UM-052	Discharge Planning to Lower level of Care, (including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days)	Discusses process to follow and requirements by the hospital to facilitate transition to lower level of care and/ or request admin days.	Formatting updates, Enhanced explaination of members who may be facing barriers to discharge	x		x	
UM	UM-056	Standing Referrals	Policy governing the management of Standing Referrals for members who require continuing specialized care over a prolonged period of time.	Addition of regulatory language clarifying the purpose and methods to authorize standing referrals.	X			
UM	UM-060	Delegation Management and Oversight	QM/UM Delegation and Oversight	Formatting updated. Changed ICE to HICE	x		x	
UM to BH	Change: UM-062 to BH-007	Behavior Health Treatment	Policy describing the provision of Behavioral Health Treatment (BHT,) such as Applied Behavioral Analysis (ABA) and others, to persons with Autism Spectrum Disorder, including coordination with Regional Center Services and Alameda County Mental Health.	Transfer of policy ownership from UM department to BH department	X			
UM	UM-063	Gender Affirmation Surgery & Services	Gender Affirmation medically necessary criteria to receive GA services for adolescents and adults, referral letter criteria, and general GA scope of care.	Added criteria for GA surgeries and procedures for adolescents, per WPATH SOC 8 guidance; updated Consent Law and Minor Consent language.	X			
UM	UM-068	Tertiary and Quartenary Review Process	Overview of T/Q academic defintions and management of service requests to these centers, for in-network and out-of-network requests.	Annual Review - Updated Cancer Centers of Excellence titles, updated active course of treatment language and continuity consistent with APL 22-032 guidance, added behavioral health for TQ decision making of authorizations. Updated audit cadence.	X		X	
UM	UM-069	Continuous Glucose Monitoring Equipment	Medical criteria and PA processed for MediCal and Group Care members	MediCal Rx transition for MediCal members will now occur on 7/1/2023 to reflect the Special Population of new Anthem members who will be eligible for COC up to 6 months.	X			

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	BH 003
Policy Name	Dyadic Services
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Medical Director / Senior Director of Behavioral Health
Lines of Business	Medi-Cal
Effective Date	TBD
Approval/Revision Date	Pending approval at Compliance Committee

POLICY STATEMENT

A. Alameda Alliance shall provide the following Behavioral Health Services including all medically necessary treatment for mental health conditions or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases, or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders when they are provided or ordered by a licensed health care professional acting within the scope of his or her license:

a. Individual/group Mental Health evaluation and treatment (psychotherapy);
b. Psychological testing when clinically indicated to evaluate a Mental Health condition;
c. Outpatient services for the purposes of monitoring drug therapy;
d. Psychiatric consultation for medication management;
e. Outpatient laboratory, supplies, and supplements;
f. Members who misuse alcohol, in accordance with Alameda Alliance Policy UM-013 Coordination of Care-Substance Abuse
g. 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.
    - Family counseling for the sole purpose of treating a couple's relational problems, including marriage counseling, is not covered.
h. Dyadic Therapy: "Dyadic care is a form of treatment that serves parents or caregivers and children together, targeting family well-being as a mechanism to support healthy child development and mental health" effective January 1, 2023. (DHCS APL 22-029 (Revised))

B. For Members under the age of twenty-one (21), Alameda Alliance shall provide Medically Necessary Dyadic Services regardless of the severity of the impairment.

1. The Dyadic Services benefit is a family and caregiver focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified and is designed to support the implementation of comprehensive models of dyadic care that works within the pediatric clinic.

a. Dyadic Services may be provided by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician. Appropriately trained nonclinical staff, including Community Health Workers (CHW), are not precluded from screening Members for issues related to SDOH or performing other nonclinical support tasks as a component of the DBH visit, as long as the screening is provider types listed above, CHWs who meet the qualifications listed in the Community Health Worker (CHW) Preventive Services section of the Provider Manual can assist a dyad to gain access to needed services to support their health, through the CHW benefit for health navigation services described in APL 22-016, or any superseding APL.
b. Dyadic Caregiver services may be provided by the medical well-child Provider.

2. Children (Members under age *21*) and their parent(s)/caregiver(s) are eligible for DBH well-child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards in Title 42 of the United States Code (USC), Section 1396d(r).
   R
3. Covered Dyadic Services are behavioral health services for children (Members under age *21*) and/or their parent(s) or caregiver(s), and include:
   a. DBH Well-Child Visits: The DBH well-child visit must be limited to those services not already covered in the medical well-child visit. When possible and operationally feasible, the DBH well-child visit should occur on the same day as the medical well-child visit. When this is not possible, the Provider will ensure the DBH well-child visit is scheduled as close as possible to the medical well-child visit, consistent with timely access requirements. The following components must be included:
      - Behavioral health history for child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.
      - Developmental history of the child.
      - Observation of behavior of child and parent(s) or caregiver(s) and interaction between child and parent(s) or caregiver(s).
      - Mental status assessment of parent(s) or caregiver(s).
      - Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.
      - Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.
      - Age-appropriate anticipatory guidance focused on behavioral health promotion/risk factor reduction, which may include:
        - Educating parent(s) or caregiver(s) on how their life experiences (e.g., Adverse Childhood Experiences
        - Educating parent(s) or caregiver(s) on how their child's life experiences (e.g., ACEs) impact their child's development.
      - Information and resources to support the child through different stages of development as indicated.
      - Making essential referrals and connections to community resources through care coordination and helping caregiver(s) prioritize needs.

b. Dyadic Comprehensive Community Supports Services: separate and distinct from California Advancing and Innovating Medi-Cal's (CalAIM) Community Supports, help the child (Member under age 21) and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:
    - Assist Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.
    - Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.
    - Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.
    - Communication and coordination of care with the child's family, medical and dental health care Providers, community resources, and other involved supports including educational, social, judicial, community and other state agencies.
    - Outreach and follow-up of crisis contacts and missed appointments.
    - Other activities as needed to address the dyad's identified treatment and/or support needs.
c. Dyadic Psychoeducational Services: for psychoeducational services provided to the child under age 21 and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of behavioral health conditions and achieving optimal mental health and long-term resilience.
d. Dyadic Family Training and Counseling for Child Development for family training and counseling provided to both the child under age 21 and parent(s) or caregiver(s). These services include brief training and counseling related to a child's behavioral issues, developmentally appropriate parenting strategies, parent/child interactions, and other related issues.
e. Dyadic Parent or Caregiver Services: Dyadic parent or caregiver services are services delivered to a parent or caregiver during a child's visit that is attended by the child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the child (Member under age 21) as appropriate:
    - Brief Emotional/Behavioral Assessment
    - CEs Screening
    - Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment
    - Depression Screening
    - Health Behavior Assessments and Interventions o Psychiatric Diagnostic Evaluation
    - Tobacco Cessation Counseling
f. Alameda Alliance will not require prior authorization for Dyadic Services. Alameda Alliance will not establish unreasonable or arbitrary barriers for accessing coverage. Encounters for Dyadic Services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.
g. Alameda Alliance will submit Encounters for Dyadic Services with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.
h. Multiple Dyadic Services are allowed on the same day and may be reimbursed at the Fee-For-Service (FFS) rate. The DBH well-child visit must be limited to those services that are not already covered in the medical well-child visit, and any other service codes cannot be duplicative of services that have already provided in a medical well-child visit or a DBH well-child visit.

i. Dyadic caregiver service codes (screening, assessment, and brief intervention services provided to the parent or caregiver for the benefit of the child) may be billed by either the medical well-child Provider or the DBH well-child visit Provider, but not by both Providers, when the dyad is seen on the same day by both Providers. Providers must bill under the Medi-Cal ID of the member under age 21 for dyadic caregiver services.
j. Tribal health programs (THPs), Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) are eligible to receive their All-Inclusive Rate from the plans if Dyadic Care services are provided by a billable Provider per APLs 17-002 and 21-008, or any superseding APLs. Dyadic Services may be reimbursed at the FFS rate established for services, if the service provided does not meet the definition of a THP, RHC, or FQHC visit, or exceeds frequency limitations. THP, RHC, and FQHC Providers can bill FFS for the four Dyadic Services codes (H1011, H2015, H2027, and T1027) delivered in a clinical setting by Provider types named in the Non-Specialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual.
k. There are no restrictions as to where Dyadic Services can be performed.
l. All Dyadic Services must be billed under the Medi-Cal ID of the Member under age 21.
m. Dyadic Services Providers are reimbursed in accordance with their Network Provider contract.

4. Family therapy is a behavioral health benefit/covered service for members under age 21 who are eligible to receive up to five family therapy sessions before a mental health diagnosis is required. Family therapy is composed of at least two family members receiving therapy together provided by a mental health Provider to improve parent/child or caregiver/child relationships and encourage bonding, resolving conflicts, and creating a positive home environment. All family members do not need to be present for each service.
    a. Members under age 21 to receive up to five family therapy sessions before a mental health diagnosis is required. Family therapy services are to be provided without regard to the five-visit limitation for Members under age 21 with risk factors for mental health disorders or parents/caregivers with related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death; foster care placement; food insecurity; housing instability; exposure to domestic violence or trauma; maltreatment; severe/persistent bullying; and discrimination.

5. Alameda Alliance will ensure that Dyadic Care Services Providers who bill for services have National Provider Identifiers (NPIs) and that these NPIs are entered in the 274 Network Provider File consistent with Alameda Alliance Policy DAT-001.
    a. Network Providers, including those that will operate as Providers of Dyadic Services, are required to enroll as Medi-Cal Providers, consistent with Alameda Alliance Policies CRE-002, CRE-020, CRE-021, CRE-023 APL 22-013, or any superseding APL, if there is a state-level enrollment pathway for them to do so.
6. Alameda Alliance is responsible for ensuring appropriate supervision of Dyadic Services Providers and for educating their Network Providers on the Dyadic Services benefit.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments responsible for clinical reviews

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program
UM-014 Identifying Abuse
UM-045 Communication Services
UM-048 Triage and Screening Services
UM-057 Authorization Requests
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-008 Member Rights to Release PHI
QI – 108 Access to Behavioral Health Services
CLS-003 Language Assistance Services
CRE-002
CRE-020
CRE-021
CRE-023
DAT-001

RELATED WORKLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy

REFERENCES

- Alameda Alliance Contract with Department of Health Care Services (DHCS)
- Alameda Alliance Policy: Member Rights and Responsibilities
- DHCS All Plan Letter (APL) 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
- DHCS APL 22-029 (Revised) Dyadic Services and Family Therapy Benefit
- DHCS 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 Healthcare Quality Committee (HCQC) for review and approval.

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POLICY AND PROCEDURE

Policy Number	BH 004
Policy Name	BHT Services
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Medical Director / Senior Director of Behavioral Health
Lines of Business	Medi-Cal
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Approval/Revision Date	Pending approval at Compliance Committee

POLICY STATEMENT

A. Alameda Alliance shall provide the following Behavioral Health Services including all medically necessary treatment for mental health conditions or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases, or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders when they are provided or ordered by a licensed health care professional acting within the scope of his or her license.

B. For members under the age of 21, the Alliance has primary responsibility for Medically Necessary Behavioral Health Treatment (BHT) provided across environments including community-based settings and on-site at schools or during virtual school sessions when medically necessary services are indicated in coordination with the Local Educational Agency (LEA).

1. The Alliance will provide supplementary BHT services and must provide BHT services to address any gap in service caused when the Local Education Agency (LEA) discontinues the provision of BHT services.

2. The Alliance will establish data and information sharing agreements as necessary to coordinate the provision of services with other entities that may have overlapping responsibility for the provision of BHT services including but not limited to the Regional Center (East Bay), Alameda County LEAs and Alameda County Behavioral Health. When another entity has overlapping responsibility to provide BHT services to the Member, the Alliance will:

3. Assess the medical needs of the Member for BHT services across community settings, according to the EPSDT standard.

4. Determine what BHT services (if any) are actively being provided by other entities.

5. Coordinate the provision of all services including Durable Medical Equipment and medication with

the other entities to ensure that the Alliance and the other entities are not providing duplicative services; and

6. Ensure that all the Member's medical needs for BHT services are being met in a timely manner, regardless of payer, and based on the individual needs of the Member.
7. The Alliance will not consider Medically Necessary BHT services to be duplicative when the Alliance has overlapping responsibility with another entity for the provision of BHT services unless the service provided by the other entity is the same type of service (e.g. ABA), addresses the same deficits, and is directed to equivalent goals.
8. The Alliance will not rely on the LEA programs to be the primary Provider of Medically Necessary BHT services on-site at school or during remote school sessions and assume that BHT services included in a Member's IEP/IHSP/IFSP are actively being provided by the LEA.
9. If the IEP team concludes that the Alliance-approved BHT services are necessary to the Member's education, the IEP team will determine that the MCP-approved BHT services will be included in the Member's IEP.
10. Services provided in the Member's IEP will not be reduced or discontinued without formal amendment of the IEP.
11. If the Alliance-contracted Provider determines that BHT services included in a member's IEP are no longer Medically Necessary, the Alliance will not use Medi-Cal funding to provide such services.
12. The Alliance may attempt to obtain written agreement from the LEA to timely take over the provision of any Alliance-approved BHT services included in the IEP upon determination that the services are no longer Medically Necessary.
13. The Alliance may coordinate with the LEA to contract directly with a school-based BHT services practitioner enrolled in Medi-Cal to provide any Medically Necessary BHT services included in a Member's IEP.

C. The Alliance has primary responsibility for ensuring the Member's needs for Medically Necessary BHT services include children diagnosed with autism spectrum disorder (ASD) and children for whom a licensed physician, surgeon, or psychologist determines that BHT services for the treatment of ASD are Medically Necessary, regardless of diagnosis.

1. The Alliance will cover all services that maintain the Member's health status, prevent a members' condition from worsening, or that prevent the development of additional health problems.
2. The Alliance will cover all necessary EPSDT services, including BHT services, regardless of whether California's Medicaid State Plan covers such services for adults, when BHT services have an ameliorative, maintenance purpose.
3. The Alliance utilizes current clinical criteria and guidelines including APL guidance and MCG guidelines when determining what BHT services are Medically Necessary and provides for independent review of the Members' medical needs for BHT services in accordance with EPSDT requirements and medically necessary accepted standards of care.
4. The Alliance ensures the Member:

    - Has a recommendation from a licensed physician, surgeon, or psychologist that evidence based BHT services are Medically Necessary,
    - Is Medically Stable,
    - Does not have a need for 24-hour medical/nursing monitoring or procedures provided in a

hospital or intermediate care facility for persons with intellectual disabilities.

5. The Alliance ensures that the BHT services are:
    - Medically Necessary,
    - Provided and supervised in accordance with an MCP-approved behavioral treatment plan that is developed by a BHT service provider who meets the requirements in California's Medicaid State Plan; and,
    - Provided by a qualified autism Provider who meets the requirements contained in California's Medicaid State Plan or a licensed Provider acting within the scope of their licensure.
    - Provided, observed, and directed under a behavioral treatment plan that has been reviewed and approved by the Alliance BCBA reviewer.
6. The Alliance will encourage the Member's Guardian (s) to be involved in the development, revision, and modification of the behavioral health treatment plan.

D. The Alliance will ensure that Members have access to and support medication adherence for the carved-out prescription drug benefit.

E. The Alliance will offer Members continued access to out-of-network Providers of BHT services (Continuity of Care) for up to 12 months in accordance with Alliance policies (UM 0-59).

F. The Alliance will provide BHT services in accordance with timely access standards, pursuant to WIC Section 14197 and the MCP contract.

G. The Alliance will comply with mental health parity requirements when providing BHT services. Treatment limitations for BHT services will not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Additionally, mental health parity requirements stipulate that the Alliance must disclose utilization management criteria.

Procedure: BHT services are evidenced-based and include but are not limited to Applied Behavioral Analysis (ABA) and the Alliance Behavioral Health Department is responsible for the management of the BHT benefit for our members according to the following procedures:

1. The Alliance Behavioral Health Navigators and staff assist the Alliance BCBA in responding to member needs throughout the course of BHT treatment and the Alliance BCBA reviews subsequent treatment reports submitted by the Qualified Autism Service Provider to ensure the Provider reviews, revises and modifies the Members' treatment plan no less than every six months. The Alliance BCBA authorizes additional BHT services based on the review of each Members' subsequent treatment plans and determine if services are no longer Medically Necessary under the EPSDT medical necessity standard..
2. The Alliance BCBA under the direction of the Senior Director of Behavioral Health or Medical Director (Doctoral Behavioral Reviewer) may consult with a board-certified consultant who has special expertise in neuropsychology and Behavioral Health Therapy including Applied Behavioral Analysis (ABA) to advise the Doctoral Behavioral Health Reviewer. The Consultant will provide a written recommendation for the applicable case. The Doctoral Behavioral Reviewer will consider the recommendation in rendering the final UM determination. The Doctoral Behavioral Reviewer will be responsible to make the UM determination.
3. 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 (BCBA).
4. If the member seeking BHT services does not have a treatment history and has not been evaluated and/or diagnosed, the member is connected with their pediatrician or a licensed

psychologist who is responsible to submit a request for appropriate BHT/ABA and or CDE services. The Alliance provides a referral form to PCPs that contains all needed information to meet the requirements needed to proceed with medically necessary BHT/ABA or CDE services.

5. 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.
6. 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.
7. The Alliance BCBA conducts a thorough assessment of the Member's history and may request additional documentation from the parent or guardian, LEA or other treating provider to determine specific treatment needs and the number of hours needed for the initial Functional Behavioral Assessment (FBA)/Initial Assessment. This initial assessment completed by the Alliance BCBA may include one or more of the following:
    - Additional evaluations or diagnostic reports.
    - Release of Information form.
    - Individual Education Plan (IEP) report for the member.
    - Reports from therapists providing any other services.
    - Previous assessments/treatment plans if applicable.
    - Previous behavior plan if applicable.
8. The Alliance BCBA reviews the information provided by the parent or guardian, LEA or other treating provider including diagnostic and assessment information and follows the DHCS APL guidance, MCG guidelines and the Council of Autism Services Provider Guidelines available on the Behavioral Analysis Certification Board's website to refer for medically necessary CDE services if a current CDE is not already available.
9. The Alliance BCBA reviews the information provided by the parent or guardian, diagnostic and assessment information and follows the DHCS APL guidance, MCG guidelines and the Council of Autism Services Provider Guidelines available on the Behavior Analysis Certification Board's website. to refer the member to a Qualified Autism Service Provider for a medically necessary Functional Behavioral Assessment (FBA) if a current FBA is not already completed.
10. The Alliance BCBA reviews the FBA and provides authorization for 6 months of BHT services utilizing The DHCS APL guidance, MCG guidelines and the Board of Behavioral Analysis guidelines and ensures the treatment plan includes:
    - A description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures, results, and evidence based BHT services.
    - Delineation of both the frequency of baseline behaviors and the treatment planned to address the behaviors.
    - Identification of measurable long, intermediate, and short-term goals and objectives that are specific, behaviorally, defined, developmentally appropriate, socially significant, and based upon clinical observation.
    - Outcome measurement assessment criteria that will be used to measure achievement of

behavior objectives.

- The Member's current level of need (baseline, expected behaviors the Guardian will demonstrate, including condition under which it must be demonstrated and mastery criteria (the objective goal), date of introduction, estimated date of mastery, specific plan for generalization and report goal as met, not met, or modified including an explanation.
- Utilization of evidence based BHT services with demonstrated clinical efficacy tailored to the Member.
- Clear identification of the place of service, service type, number of hours of direct services(s), observation and direction, Guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the Member's progress is measured and reported, transition plan, crisis plan, and each individual Provider who is responsible for delivering services.
- Care coordination that involves Guardian, school, state disability programs, and other programs and institutions, as applicable.
- Consideration of the Member's age, school attendance requirements, and other daily activities when determining the number of hours of Medically Necessary direct service and supervision. The Alliance will not reduce the number of Medically Necessary BHT hours that a member is determined to need by the hours the Member spends at school or participating in other activities.
- Plan for the delivery of BHT services in a home or community-based setting, including clinics. BHT intervention services that are provided in schools, in the home, or other community settings, must be clinically indicated, Medically Necessary and delivered in the most appropriate setting for the direct benefit of the Member. BHT service hours delivered across the settings, including during school, must be proportionate to the Member's medical need for BHT services in each setting.
- An exit plan/criteria provided that only a determination that services are no longer Medically Necessary under the EPSDT standard can be used to reduce or eliminate services.

11. Medi-Cal does not cover the following as BHT services under the EPSDT benefit:

1) Services rendered when continued clinical benefit is not expected, unless the services are determined to be Medically Necessary.
2) Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person (hereinafter, "Guardian") for costs associated with participation under the behavioral treatment plan.
3) Treatment where the sole purpose is vocationally- or recreationally-based.
4) Custodial care. For purposes of BHT services, custodial care:
a. Is provided primarily to maintain the Member's or anyone else's safety; and,
b. Could be provided by persons without professional skills or training.
5) Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
6) Services rendered by a parent or legal custodian.
7) Services that are not evidence-based behavioral intervention practice

12. Extension of Existing ABA Services:

- To request an extension on unused units close to when the authorization expires

or after the existing authorization has expired, provider must do the following:

  - Submit the most current treatment plan with the data/updates they have available and justify why they were not able to provide the services/procedures approved in the existing authorization. The request should be submitted through the provider portal as a prior-auth request auth attached clinicals/treatment plan.
  - These types of requests will be authorized for 3 months instead of 6 months.

- The Alliance BCBAs will review each request on a case-by-case basis and determine if the request meets medica necessity.
- The Alliance BCBA or BH Navigator will send notification of determination to member, PCP, servicing provider, and rendering provider.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments responsible for clinical reviews

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program
UM-014 Identifying Abuse
UM-045 Communication Services
UM-048 Triage and Screening Services
UM-057 Authorization Requests
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-008 Member Rights to Release PHI
QI – 108 Access to Behavioral Health Services
CLS-003 Language Assistance Services
BH-001 Behavioral Health Services
BH-002 Behavioral Health Services

RELATED WORKLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy

REFERENCES

- Alameda Alliance Contract with Department of Health Care Services (DHCS)
- Alameda Alliance Policy: Member Rights and Responsibilities
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21

- DHCS All Plan Letter (APL) 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services

- DHCS All Plan Letter (APL) 22-029 (Revised) Dyadic Services and Family Therapy Benefit
- 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 Service
- 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 Healthcare Quality Committee (HCQC) for review and approval.

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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	OP UM
Department Officer	Chief Medical Officer
Policy Owner	Manager, OP UM
Line(s) of Business	Medi-Cal
Effective Date	10/01/2012
Approval / Revision Date	TBD

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, in accordance with Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs) Section V.A.23.b
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PROCEDURE

1. If Alliance staff receives 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 Alliance CBAS Out of Plan Nurse is triggered. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that a Face to Face (F2F) will not be performed:
    i. Members 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 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.

ii. Written documentation of medical necessity is obtained from the Attending Physician.

iii. Alliance's Out of Plan Nurse immediately schedules a face-to-face assessment at the hospital, skilled nursing facility or a place accessible by the member

iv. The Alliance's Out of Plan Nurse completes the face-to-face assessment within 5 business days.

v. 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 (See Attachment A).

2. Eligibility determination is communicated to the member and her/his authorized representative within one (1) business day. 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.
   i. 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.
3. Approval or denial of eligibility is communicated to the CBAS center within one (1) business day of 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).
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.
   i. The Alliance approves, modifies, or denies prior authorization request within 72 hours, in accordance with Health and Safety Code 1367.01(h)(2)
   ii. The Alliance notifies the Center within 24 hours of the decision. The Alliance notifies the member within 48 hours of the decision
   iii. If the prior authorization request is approved, CBAS services areapproved with specified level of service. Services are authorized for a six-month period and CBAS services begin.
   iv. If prior authorization request is denied, a Notice of Action 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.

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.

"Case Manager" refers to a professionally trained and licensed Alliance staff member in the Case and Disease Management Department who assists assigned Members and their support systems in managing medical conditions and related psychosocial problems more effectively with the aim of improving health status and reducing the need for medical services. The Case Manager provides care coordination and is an essential member of the Interdisciplinary Care Team.

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

RELATED POLICIES AND PROCEDURES

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

CBAS Eligibility Determination Tool (CEDT)

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 5/21/2020, 05/20/2021, 06/28/2022

REFERENCES

DHCS CBAS Contract, Exhibit A, Attachment 20.4
DHCS Contract, Exhibit E, Additional Provisions, Attachment 1, Definitions
Health and Safety Code 1367.01
Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, amended 4/1/2012

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-002
Policy Name	Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility
Department Name	OP UM
Department Officer	Chief Medical Officer
Policy Owner	Manager, OP UM
Line(s) of Business	Medi-Cal
Effective Date	10/01/2012
Approval / Revision Date	~~6/28/2022~~TBD

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, ~~or~~ who is at high risk of admission to a skilled nursing facility, or faces an imminent and serious threat to their health, in accordance with Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs) Section V.A.23.b.

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PROCEDURE

1. If Alliance staff receives 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 Alliance CBAS Out of Plan Nurse is triggered. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that a Face to Face (F2F) will not be performed:
    i. Members 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 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.

i. ~~The Alliance's Out of Plan Nurse immediately schedules a face-to-face assessment at the hospital, skilled nursing facility or a place accessible by the member.~~

ii. Written documentation of medical necessity is obtained from the Attending Physician.

iii. Alliance's Out of Plan Nurse immediately schedules a face-to-face assessment at the hospital, skilled nursing facility or a place accessible by the member

~~iii.~~iv. The Alliance's Out of Plan Nurse completes the face-to-face assessment within 5 business days.

~~iv.~~v. 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 (See Attachment A).

2. Eligibility determination is communicated to the member and her/his authorized representative within one (1) business day. 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.
   i. 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.
3. Approval or denial of eligibility is communicated to the CBAS center within one (1) business day of 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).
4. After the ~~three day~~three-day assessment is completed, the CBAS center submits the IPC with Level of Service recommendation and a prior authorization request to the Alliance.
   i. The Alliance approves, modifies, or denies prior authorization request within 72 hours, in accordance with Health and Safety Code 1367.01(h)(2)
   ii. The Alliance notifies the Center within 24 hours of the decision. The Alliance notifies the member within 48 hours of the decision
   iii. If the prior authorization request is approved, CBAS services areapproved with specified level of service. Services are authorized for a six-month period and CBAS services begin.
   iv. If prior authorization request is denied, a Notice of Action 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.

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.

"Case Manager" refers to a professionally trained and licensed Alliance staff member in the Case and Disease Management Department who assists assigned Members and their support systems in managing medical conditions and related psychosocial problems more effectively with the aim of improving health status and reducing the need for medical services. The Case

Manager provides care coordination and is an essential member of the Interdisciplinary Care Team.

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

~~**"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 CalAIM Demonstration Waiver 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 ~~document~~ 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 ~~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.

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

RELATED POLICIES AND PROCEDURES

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

CBAS Eligibility Determination Tool (CEDT)

REVISION HISTORY

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06/16/2016, 09/06/2018, 04/15/2019, 5/21/2020, 05/20/2021, 06/28/2022

REFERENCES

DHCS CBAS Contract, Exhibit A, Attachment 20.4
DHCS Contract, Exhibit E, Additional Provisions, Attachment 1, Definitions
Health and Safety Code 1367.01
Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, amended 4/1/2012

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	OP UM Management
Department Officer	Chief Medical Officer
Policy Owner	Manager, OP UM
Line(s) of Business	Medi-Cal
Effective Date	10/01/2012
Approval / Revision Date	TBD

POLICY STATEMENT

A. Alliance supports Member preference in the assignment of Community Based Adult Services (CBAS) center.

B. The Alliance promotes CBAS services as an option for all eligible Members.

C. 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.

D. 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

A. Member accesses CBAS through:
   1) Self or family and/or caregiver
   2) Primary Care Provider
   3) Alliance internal departments: such as the Intake Unit, Case Management, Member Services Unit and/or Utilization Management
   4) Skilled nursing facility or acute-care facility
   5) Home or Community-Based Organization (HCBO)
   6) CBAS provider/center

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

C. 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.

D. If the requested CBAS center is closed to new enrollees due to capacity limitations, the Member and/or Authorized Representative may choose to:

1) Waitlist for an opening at the CBAS center of choice

a. 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.

2) 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.

3) Accept unbundled equivalent CBAS services (see Alliance Policy and Procedure CBAS 005 Provision of Unbundled CBAS Services).

E. If a member is unable to choose or does not wish to make the selection, the Alliance's Out of Plan Nurse contacts CBAS providers to determine capacity. The RN will assign the Member to a CBAS site using the following preferential order:

1) Disease specific

2) Member's relationship with a previous provider of services similar to CBAS

3) Language/culture appropriate

4) Geographically appropriate (closest to member's place of residence, and involving reasonable transport.).

F. Member request for a specific CBAS center may be denied by the Alliance for the following reasons:

1) The requested CBAS Provider is full and not accepting new participants.

2) The requested PCP had previously discharged the Member from his/her CBAS center

G. 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.

DEFINITIONS / ACRONYMS

"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.

“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.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

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

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 5/21/2020, 5/20/2021, 06/28/2022

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REFERENCES

DHCS Contract, Exhibit A, Attachment 18

MONITORING

This policy will be reviewed annually to ensure effectiveness.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CBAS-004
Policy Name	Member Assignment to a Community-Based Adult Service (CBAS) Center
Department Name	OP UM Management
Department Officer	Chief Medical Officer
Policy Owner	Manager, OP UM
Line(s) of Business	Medi-Cal
Effective Date	10/01/2012
Approval / Revision Date	~~6/28/2022~~TBD

POLICY STATEMENT

A. Alliance supports Member preference in the assignment of Community Based Adult Services (CBAS) center.

B. The Alliance promotes CBAS services as an option for all eligible Members.

C. 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.

D. 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

A. Member accesses CBAS through:
   1) Self or family and/or caregiver
   2) Primary Care Provider
   3) Alliance internal departments: such as the Intake Unit, Case Management, Member Services Unit and/or Utilization Management
   4) Skilled nursing facility or acute-care facility
   5) Home or Community-Based Organization (HCBO)
   6) CBAS provider/center

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

C. 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.

D. If the requested CBAS center is closed to new enrollees due to capacity limitations, the Member and/or Authorized Representative may choose to:

1) Waitlist for an opening at the CBAS center of choice

a. 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.

2) 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.

3) Accept unbundled equivalent CBAS services (see Alliance Policy and Procedure CBAS 005 Provision of Unbundled CBAS Services).

E. If a member is unable to choose or does not wish to make the selection, the Alliance's Out of Plan Nurse contacts CBAS providers to determine capacity. The RN will assign the Member to a CBAS site using the following preferential order:

1) Disease specific

2) Member's relationship with a previous provider of services similar to CBAS

3) Language/culture appropriate

4) Geographically appropriate (closest to member's place of residence, and involving ~~the~~ reasonable transport.).

F. Member request for a specific CBAS center may be denied by the Alliance for the following reasons:

1) The requested CBAS Provider is full and not accepting new participants.

2) The requested PCP had previously discharged the Member from his/her CBAS center

G. 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.

DEFINITIONS / ACRONYMS

"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.

“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.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

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

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 5/21/2020, 5/20/2021, 06/28/2022

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REFERENCES

DHCS Contract, Exhibit A, Attachment 18

MONITORING

This policy will be reviewed annually to ensure effectiveness.

Cultural and Linguistic Program Description

2024

APROVAL DATE

Alameda Alliance for Health
Cultural and Linguistic Services Program Description
2024

Overview

The Alameda Alliance for Health (Alliance) is committed to delivering culturally and linguistically appropriate services (CLAS), to all eligible Medi-Cal and Group Care members. The Alliance's Cultural and Linguistic Services Program complies with 22 CCR sections 51202.5 and 51309.5(a), 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04 (c)(2)(G)(v) - (c)(4), 42 CFR section 438.206(c)(2), Title VI of the Civil Rights Act of 1964, section 1557 of the Affordable Care Act of 2010, 42 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights), and APL 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services. The Alliance CLS Program aligns with the National Standards for Cultural and Linguistically Appropriate Services (CLAS) created by the U.S. Department of Health & Human Services (CLAS Standards - Think Cultural Health (hhs.gov).

The goal of the Cultural and Linguistic Services (CLS) Program is to ensure that all members receive equitable access to high quality health care services, including behavioral health services, that are culturally and linguistically appropriate. This includes ensuring culturally appropriate services and access for members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56.

Program objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer its members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic program through cultural competency training.
- Identify, inform, and assist limited English proficiency (LEP) members in accessing quality interpretation services.
- Ensure that Alliance health care providers follow the Alliance CLS Program.
- Integrate community input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.

The Organizational Chart in Appendix B displays reporting relationships for the Alliance organization and identifies key staff with overall responsibility for the operation of the CLS Program.

Cultural and Linguistic Services Leadership

The **Quality Improvement Department** is responsible for developing, implementing, and evaluating the Alliance's Cultural and Linguistic Services Program in coordination with other Alliance departments including Provider Services, Human Resources, Analytics and Performance, Member Services, Communications and Outreach, Quality Assurance, Vendor

Management and Compliance.

Population Health and Equity is a part of the Alliance's Quality Improvement Department. The Manager of Cultural and Linguistic Services, under the direction of the Director of Population Health and Equity, and in collaboration with the aforementioned departments, develops the CLS Program work plan and integrates information and resources on cultural competency into the Alliance's programs and services. The Manager of Cultural and Linguistic Services also facilitates the Cultural and Linguistic Services Subcommittee (CLSS) of the Quality Improvement Health Equity Committee (QIHEC), which in turn reports to the Alliance Board of Governors. All participating persons/departments report ultimately to the Chief Executive Officer.

The **Director of Population Health and Equity** who oversees the Manager of Cultural and Linguistic Services has a Master's in Public Health with a concentration in Community Health Education and over 30 years' experience leading culturally and linguistically appropriate services. The staff include individuals who have bilingual capacity and experience in medical interpretation, program development in diverse Medi-Cal populations, and working with people with disabilities.

The **Chief Health Equity Officer** partners with leaders across the organization to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI) for members, providers, and employees.

The Manager of Cultural and Linguistic Services and the Communications and Outreach Senior Manager are responsible for supporting the **Alliance Community Advisory Committee (CAC)** (see below for description) in accordance with Title 22, CCR, Section 53876 (c). The Health Programs Coordinator provides administrative support to the CAC.

Departmental Roles

The **Behavioral Health (BH) Department** oversees services provided for members with Mental Health Disease and Autism Spectrum Disorder. In April of 2023, Alameda Alliance has de-delegated responsibility of these services and is now responsible for the Program work plan. The BH team integrates information and resources on cultural competency into the Alliance's programs. It is also responsible for behavioral health utilization and case management activities including triage and referral and participation on the multi-disciplinary case management teams. The team is led by the Senior Director of Behavioral Health (Licensed Psychologist) and Senior Medical Director (MD).

The **Communications and Outreach Departmen**t is responsible for ensuring that marketing practices for eligible beneficiaries or potential enrollees do not discriminate due to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. In addition, they take into consideration results from member surveys and assessments, community feedback and other CLS monitoring activities when producing member materials. The department is also responsible for quality translations of member written materials and communications and assists all departments in sending the appropriate non-discrimination and language assistance service notices to members.

Compliance is responsible for conducting audits of the Alliance CLS Program, monitoring delegated CLS responsibilities, and ensuring that all state and federal regulations are followed.

Health Education, also a part of Quality Improvement, staff ensure that members have access to

qualified interpreters when participating in health education programs and make health education materials available to members and providers that meet the literacy, cultural, linguistic, clinical, and regulatory standards.

The **Human Resources (HR) Department** is responsible for bilingual assessment of new staff who will use their bilingual skills with members. They maintain a listing of Alliance bilingual staff and ensure quality monitoring of bilingual staff is not monitored through the Member Services quality assurance program. HR also ensures Alliance staff complete Diversity, Equity, and Inclusion (DEI) trainings, including participation in the cultural sensitivity training, annually.

The **Member Services Department** assesses member cultural and linguistic needs at each contact by identifying and verifying language preferences, reported ethnicity and preference for use of interpreter services. Members are informed that they can access no cost oral interpretation in their preferred language and written materials translated into Alliance threshold languages or provided in alternative formats. Member Services also monitors call quality of Member Services Representatives' ability to follow cultural and linguistic protocols.

The **Provider Services Department** is responsible for ensuring that the Alliance provider network composition continuously meets members' cultural and linguistic needs. Provider Services also trains providers on the Alliance Cultural and Linguistic program requirements. Language capabilities of clinicians and other provider office staff are identified during the credentialing process and providers update language capacity with the Alliance regularly.

The **Quality Assurance Department** supports the CLS program through monitoring and reporting of grievances related to CLS services.

Quality Improvement Specialists conduct member and provider surveys, and Quality Nurses conduct medical record and facility site reviews that monitor CLS requirement implementation at the provider office level and issue corrective action plans as needed.

Vendor Management supports compliance oversight of language services vendors and implements corrective action plans as needed.

Community Advisory Committee

The **Community Advisory Committee (CAC)** is supported by the Senior Manager of Communications and Outreach and Manager of Cultural and Linguistic Services and their respective departments. The purpose of the CAC is to provide a link between the Alliance and the community. The CAC advises the Alliance on the development and implementation of policies and procedures that affect cultural and linguistic access, quality, and health equity. The committee's responsibilities include:

a. Identify and advocate for preventive care practices to be used by the Alliance.
b. Develop and update cultural and linguistic policy and procedures related to cultural competency issues, educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability.
c. Advise on Alliance member and provider-targeted services, programs, and trainings.
d. Provide and make recommendations about the cultural appropriateness of communications, partnerships, and services.
e. Review findings from the Population Needs Assessment (PNA) and discuss improvement opportunities on Health Equity and Social Drivers of Health and provide input on selecting targeted

health education, cultural and linguistic, and Quality Improvement (QI) strategies.
f) Provide input and advice, including, but not limited to, the following:
i. Culturally appropriate service or program design
ii. Priorities for health education and outreach program
iii. Member satisfaction survey results
iv. PNA findings
v. Marketing materials and campaigns
vi. Communication of needs for network development and assessment
vii. Community resources and information
viii. Population Health Management
ix. Quality
x. Health delivery systems to improve health outcomes
xi. Carved out services
xii. Coordination of care
xiii. Health Equity
xiv. Accessibility of services
xv. Development of the provider manual and clarification of new and revised policies and procedures in the manual.

The CAC is comprised of Alliance members, community advocates, safety net providers, and at least one traditional provider.

The CAC enables the Alliance to maintain community partnerships with consumers, community advocates and traditional and safety net providers regarding CLAS.

Standards and Performance Requirements

The Alliance's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. The Alliance has systems and processes to:

- Provide all members – including those with mental health and autism spectrum disorder - access to no cost language assistance services at all points of contact, 24 hours a day, 7 days a week. Educate members and providers about the availability of language services and how to access them.

- Assess and track linguistic capability of interpreters, bilingual employees, and contracted staff in medical and non-medical settings. Implement a system to provide adequate training regarding the Alliance language assistance programs to all employees and contracted staff that have routine contact with LEP Members or Potential Members.

- Conduct a Population Needs Assessment (PNA) according to the DHCS timeline to:
  - Identify member health needs and health disparities.
  - Evaluate health education, CLS, and quality improvement (QI) activities and available resources to address identified concerns.
  - Implement targeted strategies for health education, CLS, and QI programs and services.
  - Share with relevant stakeholders and inform the cultural and linguistic services program priorities.

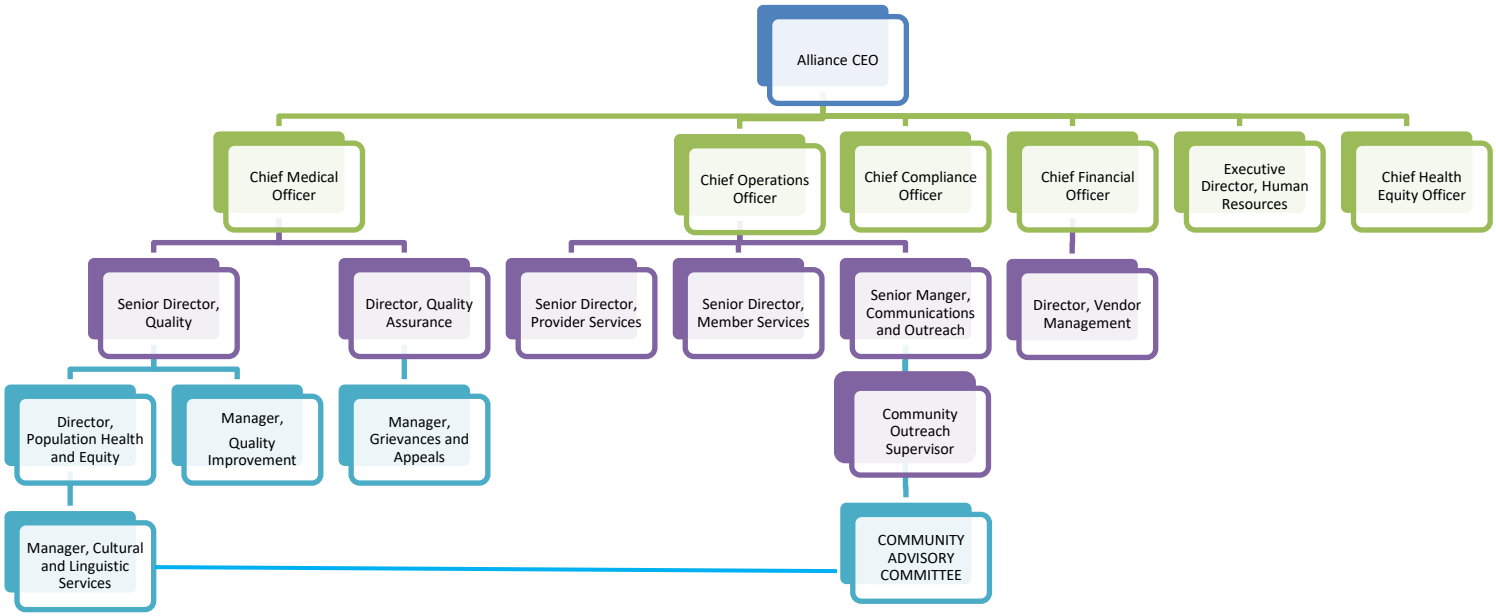
- Provide annual Diversity, Equity and Inclusion Training that covers sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings for staff, providers, and clinical and non-clinical contracted staff. The training will cover the Alliance Cultural and Linguistic Program, language and literacy, gender affirming care, as well as working with identified diverse cultural groups within the Alliance service areas.

- Monitor and evaluate the Cultural and Linguistic Services Program and the performance of individuals providing linguistics services. The Alliance tracks and addresses any identified gaps in the Alliance's ability to address members' cultural and linguistic needs.

The program meets the standards detailed in the following Alliance Policies and Procedures:

- CLS-001: Cultural and Linguistic Services Program Description
- CLS-002: Cultural and Linguistic Services Program - Member Advisory Committee
- CLS-003: Cultural and Linguistic Services Program – Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
- CLS-008: Cultural and Linguistic Services Program - Member Assessment of Cultural and Linguistic Needs
- CLS-009: Cultural and Linguistic Services Program – Contracted Providers
- CLS-010: Cultural and Linguistic Services Program - Staff Training and Assessment
- CLS-011: Cultural and Linguistic Services Program – Compliance Monitoring

Alameda Alliance for Health Organizational Chart
Cultural and Linguistic Services
APPENDIX B



Cultural and Linguistic Program Description

2024~~3~~

APROVAL DATE

Alameda Alliance for Health
Cultural and Linguistic Services Program Description
2024~~3~~

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Program objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer its members culturally and linguistically appropriate services.
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- Integrate community input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities aimed at achieving cultural competence and reducing health care disparities.

~~**The Work Plan** for the C & L Program in Appendix A includes a timetable for implementation of activities related to meeting the program goal and objectives.~~

The Organizational Chart in Appendix B displays reporting relationships for the Alliance organization and identifies key staff with overall responsibility for the operation of the CLS~~ultural and Linguistic Services~~ Program.

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Cultural and Linguistic Services Leadership

The **Quality Improvement Department** is responsible for developing, implementing, and evaluating the Alliance's Cultural and Linguistic Services Program in coordination with other Alliance departments including Provider Services, Human Resources, Analytics and Performance, Member Services, Communications and Outreach, Quality Assurance, Vendor Management and Compliance.

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The **Director of Population Health and Equity** who oversees the Manager of Cultural and Linguistic Services has a Master's in Public Health with a concentration in Community Health Education and over 30 years' experience leading culturally and linguistically appropriate services. The staff include individuals who have bilingual capacity and experience in medical interpretation, program development in diverse Medi-Cal populations, and working with people with disabilities.

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The Manager of Cultural and Linguistic Services and the Communications and Outreach Senior Manager are responsible for supporting the **Alliance ~~Member~~ Community Advisory Committee (CAC)** (see below for description) in accordance with Title 22, CCR, Section 53876 (c). The Health Programs Coordinator provides administrative support to the ~~Member Advisory Committee~~CAC.

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Departmental Roles

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The **Communications and Outreach D~~d~~epartment** is responsible for ensuring that marketing practices for eligible beneficiaries or potential enrollees do not discriminate due to race, color,

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national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. In addition, they take into consideration results from member surveys and assessments, community feedback and other CLS monitoring activities when producing member materials. The department is also responsible for quality translations of member written materials and communications and assists all departments in sending the appropriate non-discrimination and language assistance service notices to members.

Compliance is responsible for conducting audits of the Alliance ~~Cultural and Linguistic Services~~CLS P~~p~~rogram, monitoring delegated CLS responsibilities, and ensuring that all state and federal regulations are followed.

Health Education, also a part of Quality Improvement, staff ensure that members have access to qualified interpreters when participating in health education programs and make health education materials available to members and providers that meet the literacy, cultural, linguistic, clinical, and regulatory standards.

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The **Provider Services D~~d~~epartment** is responsible for ensuring that the Alliance provider network composition continuously meets members' cultural and linguistic needs. Provider Services also trains providers on the Alliance Cultural and Linguistic program requirements. Language capabilities of clinicians and other provider office staff are identified during the credentialing process and providers update language capacity with the Alliance regularly.

The **Quality Assurance ~~department~~ Department** supports the CLS program through monitoring and reporting of grievances related to CLS services.

Quality Improvement Specialists conduct member and provider surveys, and Quality Nurses conduct medical record and facility site reviews that monitor CLS requirement implementation at the provider office level and issue corrective action plans as needed.

Vendor Management supports compliance oversight of language services vendors and implements corrective action plans as needed.

Community Advisory Committee

The **Community Advisory Committee ~~at the Alliance is known as the Member Advisory Committee~~**

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(CMAC) . The **MAC** is supported by the Senior Manager of Communications and Outreach and Manager of Cultural and Linguistic Services and their respective departments. The purpose of the Member Advisory Committee (CMAC) is to provide a link between the Alliance and the community. The CMAC advises the Alliance on the development and implementation of policies and procedures that affect cultural and linguistic access, quality, and health equity. its cultural and linguistic accessibility standards and procedures. The committee's responsibilities include:

a. Identify and advocate for preventive care practices to be used by the Alliance.

b. Develop and update cultural and linguistic policy and procedures related to cultural competency issues, educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability.

c. Advise on Alliance member and provider-targeted services, programs, and trainings.

d. Provide and make recommendations about the cultural appropriateness of communications, partnerships, and services.

e. Review findings from the Population Needs Assessment (PNA) and discuss improvement opportunities on Health Equity and Social Drivers of Health and provide input on selecting targeted health education, cultural and linguistic, and Quality Improvement (QI) strategies.

f) Provide input and advice, including, but not limited to, the following:

i. Culturally appropriate service or program design
ii. Priorities for health education and outreach program
iii. Member satisfaction survey results
iv. PNA findings
v. Marketing materials and campaigns
vi. Communication of needs for network development and assessment
vii. Community resources and information
viii. Population Health Management
ix. Quality
x. Health delivery systems to improve health outcomes
xi. Carved out services
xii. Coordination of care
xiii. Health Equity
xiv. Accessibility of services
xv. Development of the provider manual and clarification of new and revised policies and procedures in the manual.

advising on cultural competency issues, and educational and operational issues affecting members, including seniors, people who speak a primary language other than English, and persons with disabilities.

The CMAC is comprised of Alliance members, community advocates, safety net providers, and at least one traditional provider.

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The MAC provides input about members' cultural and linguistic needs and the Alliance cultural and linguistic access standards (CLAS) and procedures. The MACCAC enables the Alliance to maintain community partnerships with consumers, community advocates and traditional and safety net providers regarding CLAS. Alliance procedures ensure MAC involvement in policy decisions related to educational, operational, and cultural competency decisions affecting groups that speak a primary language other than English.

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Standards and Performance Requirements

The Alliance's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. The Alliance

has systems and processes to:

- Provide all members – including those with mental health and autism spectrum disorder - access to no cost language assistance services at all points of contact, 24 hours a day, 7 days a week. Educate members and providers about the availability of language services and how to access them.

- Assess and track linguistic capability of interpreters, bilingual employees, and contracted staff in medical and non-medical settings. Implement a system to provide adequate training regarding the Alliance language assistance programs to all employees and contracted staff that have routine contact with LEP Members or Potential Members.

- Conduct a Population Needs Assessment (PNA) according to the DHCS timeline to:
  - Identify member health needs and health disparities.
  - Evaluate health education, CLS, and quality improvement (QI) activities and available resources to address identified concerns.
  - Implement targeted strategies for health education, CLS, and QI programs and services.
  - Share with relevant stakeholders and inform the cultural and linguistic services program priorities.

- Provide annual Diversity, Equity and Inclusion Training that covers sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings for staff, providers, and clinical and non-clinical contracted staff. The training will cover the Alliance Cultural and Linguistic Program, language and literacy, gender affirming care, as well as working with identified diverse cultural groups within the Alliance service areas.

- Monitor and evaluate the Cultural and Linguistic Services Program and the performance of individuals providing linguistics services. The Alliance tracks and addresses any identified gaps in the Alliance's ability to address members' cultural and linguistic needs.

The program meets the standards detailed in the following Alliance Policies and Procedures:

- CLS-001: -Cultural and Linguistic Services Program Description
- CLS-002: -Cultural and Linguistic Services Program - Member Advisory Committee
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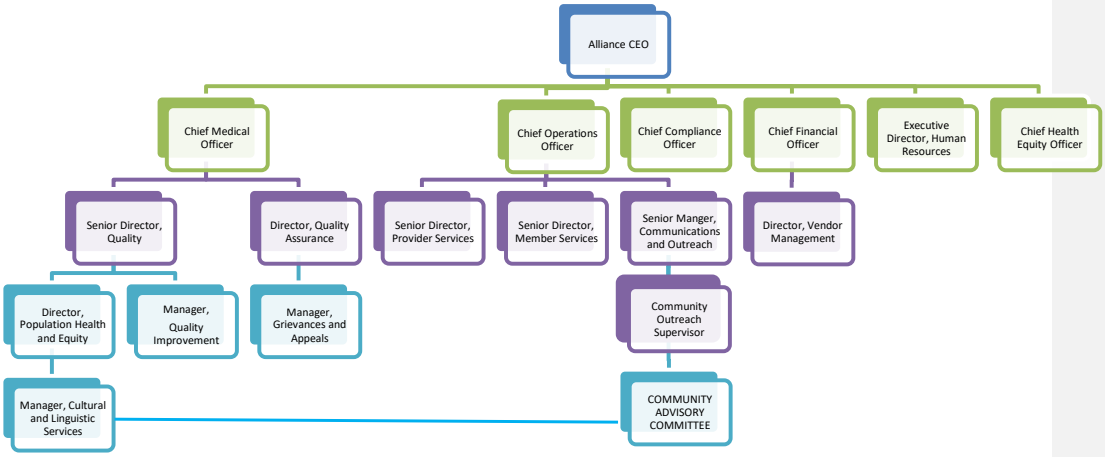
- CLS-009: -Cultural and Linguistic Services Program – Contracted Providers
- CLS-010: -Cultural and Linguistic Services Program - Staff Training and Assessment
- CLS-011: -Cultural and Linguistic Services Program – Compliance Monitoring

Alameda Alliance for Health Workplan
Cultural and Linguistic Services
2023

Resp Party/ Business Lead	Project Manager	QI Activity/Initiative	Goal	Due Date/ Timeframe for Completion
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Member Cultural and Linguistic Assessment	Assess the cultural and linguistic needs of plan enrollees.	1/31/2023 4/31/2023 7/31/2023 10/31/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Language Assistance Services	Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	3/31/2023 6/30/2023 9/30/2023 12/31/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Provider Language Capacity (Member Satisfaction)	Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	3/31/2023 6/30/2023 9/30/2023 12/31/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Provider Language Capacity (Provider Network)	Complete NCQA NET 1 A Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.	6/30/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD)	Cultural Sensitivity Training -Participation	96% of Alliance staff will participate in the annual Cultural Sensitivity training.	12/31/2023
Director, Population Health and Equity (Linda Ayala)	Manager, Cultural and Linguistic Services (TBD	Cultural Sensitivity Training -Enhancements	Facilitate collaborative process to update Cultural Sensitivity Training (s) to meet DHCS 2024 requirements.	12/31/2023
Director, Population Health and Equity (Linda Ayala)	Manager, cultural and Linguistic Services	Member Advisory Committee	Ensure implementation of DHCS 2024 Contract updates to Member Advisory Committee and community engagement.	12/31/2023

Alameda Alliance for Health Organizational Chart
Cultural and Linguistic Services
APPENDIX B



ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	CLS-001
Policy Name	Cultural and Linguistic Program Description
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal and Group Care
Effective Date	1/1/2007
Subcommittee	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

The Alameda Alliance for Health ("Alliance") is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible members, including Medi-Cal and Group Care lines of business. The Alliance's Cultural and Linguistic Services (CLS) Program complies with Title VI of the Civil Rights Act of 1964, U.S. Code of Federal Regulations, Title 42, CFR Section 440.262 , Patient Protection and Affordable Care Act, Section 1557, California Code of Regulations Title 22, Sections 51202.5 and 51309.5(a), 53853(c) and Title 28, sections 1300.67.04(c)(2)(A)-(B) and 1300.67.04 (c) (2)(G)(v) – (c) (4), Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017), SB 1423 (Hernandez, Chapter 568, Statutes of 2018) and with the Cultural and Linguistic Services requirements of the Alliance's contracts with the California Department of Health Care Services (DHCS).

The Alliance Population Needs Assessment (PNA) plays an important role in informing the Alliance Cultural and Linguistic Services Program. The PNA offers a comprehensive look at the member health needs and disparities, identifies gaps in services, and defines targeted strategies to address those gaps. The Alliance CLS Program is reviewed and updated

regularly to align with the PNA. See *HED-003 Population Needs Assessment* for additional details.

Alliance network providers, subcontractors, and downstream contractors, as a part of their responsibility to comply with the Alliance CLS program, also offer CLS services that align with the PNA.

PROCEDURE

See Attachment 1 – Alameda Alliance for Health Cultural and Linguistic Services Program Description

DEFINITIONS / ACRONYMS

CCR: California Code of Regulations
CFR: Code of Federal Regulations
CLAS: Culturally and Linguistically Appropriate Services
CLS: Cultural and Linguistic Services
DHCS: Department of Health Care Services
PNA: Population Needs Assessment

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Provider Network

RELATED POLICIES AND PROCEDURES

CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-008 Cultural and Linguistic Services Program - Member Assessment
CLS-009 Cultural and Linguistic Services Program - Contracted Providers
PH-005 Population Assessment

REVISION HISTORY

1/1/07, 1/1/08, 9/2009, 2/26/2010, 4/13/15, 3/24/2016, 11/10/2016, 5/25/2017, 5/3/2018, 5/16/2019, 3/19/2020, 3/18/2021, 3/22/2022, 3/21/2023, TBD

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alameda Alliance for Health Cultural and Linguistic Services Program Description

REFERENCES

DHCS Contract Attachment 9, Sec. 11-13
DHCS All Plan Letter 21-004
Title VI, Civil Rights Act of 1964
Title 22, CCR, Sections 51202.5 and 51309.5(a). 53853(c)
Title 28, CCR sections 1300.67.04(c)(2)(A)-(B) and 1300.67.04 (c) (2)(G)(v) – (c) (4)U.S. Code of Federal Regulations, Title 42, CFR Section 440.262
Patient Protection and Affordable Care Act, Section 1557
Senate Bill 223 (Atkins, Chapter 771, Statutes of 2017)
Senate Bill 1423 (Hernandez, Chapter 568, Statutes of 2018)

MONITORING

This policy will be reviewed annually to ensure effectiveness and that it meets regulatory and contractual standards. Monitoring activities of the Cultural and Linguistic Services Program are described in the Alliance Policy *CLS-011 Compliance Monitoring of Cultural and Linguistic Services.*

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ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CLS-001
Policy Name	Cultural and Linguistic Program Description
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal and Group Care
Effective Date	1/1/2007
Subcommittee	~~Health Care~~ Quality Improvement ~~and~~ Health Equity Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	~~3/21/2023~~TBD

POLICY STATEMENT

The Alameda Alliance for Health ("Alliance") is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible members, including Medi-Cal and Group Care lines of business. The Alliance's Cultural and Linguistic Services (CLS) Program complies with Title VI of the Civil Rights Act of 1964, U.S. Code of Federal Regulations, Title 42, CFR Section 440.262 , Patient Protection and Affordable Care Act, Section 1557, California Code of Regulations Title 22, Sections 51202.5 and 51309.5(a), 53853(c) and Title 28, sections 1300.67.04(c)(2)(A)-(B) and 1300.67.04 (c) (2)(G)(v) – (c) (4), Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017), SB 1423 (Hernandez, Chapter 568, Statutes of 2018) and with the Cultural and Linguistic Services requirements of the Alliance's contracts with the California Department of Health Care Services (DHCS).

The Alliance Population Needs Assessment (PNA) plays an important role in informing the Alliance Cultural and Linguistic Services P~~p~~rogram. The PNA offers a comprehensive look at the member health needs and disparities, identifies gaps in services, and defines targeted strategies to address those gaps. The Alliance CLS Program is reviewed and updated

regularly to align with the PNA. See *HED-003 Population Needs Assessment* for additional details.

Alliance network providers, subcontractors, and downstream contractors, as a part of their responsibility to comply with the Alliance CLS program, also offer CLS services that align with the PNA.

PROCEDURE

See Attachment 1 – Alameda Alliance for Health Cultural and Linguistic Services Program Description

DEFINITIONS / ACRONYMS

CCR: California Code of Regulations
CFR: Code of Federal Regulations
CLAS: Culturally and Linguistically Appropriate Services
CLS: Cultural and Linguistic Services
DHCS: Department of Health Care Services
PNA: Population Needs Assessment

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AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Provider Network

RELATED POLICIES AND PROCEDURES

CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-008 Cultural and Linguistic Services Program - Member Assessment
CLS-009 Cultural and Linguistic Services Program - Contracted Providers
~~HED-003~~PH-005 Population ~~Needs~~ Assessment

REVISION HISTORY

1/1/07, 1/1/08, 9/2009, 2/26/2010, 4/13/15, 3/24/2016, 11/10/2016, 5/25/2017, 5/3/2018, 5/16/2019, 3/19/2020, 3/18/2021, 3/22/2022, 3/21/2023, TBD

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alameda Alliance for Health Cultural and Linguistic Services Program Description

REFERENCES

DHCS Contract Attachment 9, Sec. 11-13
DHCS All Plan Letter 21-004
Title VI, Civil Rights Act of 1964
Title 22, CCR, Sections 51202.5 and 51309.5(a). 53853(c)
Title 28, CCR sections 1300.67.04(c)(2)(A)-(B) and 1300.67.04 (c) (2)(G)(v) – (c) (4)U.S. Code of Federal Regulations, Title 42, CFR Section 440.262
Patient Protection and Affordable Care Act, Section 1557
Senate Bill 223 (Atkins, Chapter 771, Statutes of 2017)
Senate Bill 1423 (Hernandez, Chapter 568, Statutes of 2018)

MONITORING

This policy will be reviewed annually to ensure effectiveness and that it meets regulatory and contractual standards. Monitoring activities of the Cultural and Linguistic Services Program are described in the Alliance Policy *CLS-011 Compliance Monitoring of Cultural and Linguistic Services.*

POLICY AND PROCEDURE

Policy Number	CLS-002
Policy Name	Community Engagement
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal and Group Care
Effective Date	4/1/1999
Subcommittee	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

The Alameda Alliance for Health (the Alliance) community engagement strategy ensures that members and families are partners in the delivery of covered services. The Alliance community engagement efforts encourage Alliance members and families to participate in the public policy of the health plan and the development of programs that ensure health care access and dignity for its diverse members. The structure, functions, accountability, and scope of community engagement shall be in accordance with applicable regulations and contracts.

The Alliance community engagement strategy follows applicable laws and Department of Healthcare Services mandates including Title 22 California Code of Regulations section 53876 (c), Title 28, California Code of Regulations, Section 1300.69, and the 2024 DHCS Single Plan Contract Exhibit A.

PROCEDURE

1. The Alliance community engagement strategy includes the following elements:
   1.1. Maintaining an organizational leadership commitment to engaging members and families in the delivery of care through adequate funding of resources to promote community engagement activities and support the dissemination of community engagement results.
   1.2. Quality and health equity initiatives routinely engage members and families through focus groups, listening sessions, surveys and/or interviews. The findings,

recommendations, and results are incorporated into policies and decision-making and inform interventions.

1.3. As the Alliance creates new initiatives or process updates, project leaders consider whether member and family feedback will be needed, what would be the best format, and how to incorporate the feedback into updated policies and decision-making.

1.4. Members who participate in the process will be informed of the impact of their feedback through community meetings or other forms of communication.

1.5. The Alliance maintains documentation of member feedback and results in order to ensure accountability for incorporating member and family input into policies and decision-making.

1.6. Member engagement and input is incorporated into the Quality Improvement and Health Equity Program Evaluation to measure and monitor the impact of the input. (*QI-101 Quality Improvement Program*)

1.7. The Alliance conducts member surveys and incorporates the results in quality improvement and health equity activities. (*QI-117 Member Satisfaction Survey)*

1.8. The Alliance has a Community Advisory Committee (CAC) that meets regularly to provide diverse member and family input into Alliance policies, procedures, and programs. The findings and recommendations inform Alliance activities and interventions.

1.9. The CAC is comprised primarily of Alliance members, as part of the Alliance's implementation and maintenance of member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.

1.10. The Alliance partners with community-based organizations to cultivate member and family engagement.

1.11. The CAC's input is actively utilized in policies and decision-making.

2. Community Advisory Committee Membership

2.1. The Alliance convenes a selection committee tasked with selecting the members of the CAC. The Alliance makes a good faith effort to ensure that the CAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC.

2.1.1. Alliance BOG representatives including Safety Net Providers, Federally Qualified Health Centers (FQHCs), behavioral health, regional centers, local education authorities, dental Providers, Indian Health Service (IHS) Facilities, and home and community-based Providers.

2.1.2. Persons and community-based organizations who represent the diversity of Alameda County.

2.2. The Committee membership reflects the general Medi-Cal member population in Alameda County, including the following or their representatives:

2.2.1. Representatives from any Indian Health Service providers

2.2.2. Adolescents and/or parents and/or caregivers of children, including foster

youth.

2.3. The make-up of the CAC is adjusted as the community changes to ensure the community is represented and engaged and makes a good faith effort to include representatives from diverse and hard to reach populations, with a specific emphasis on:
  2.3.1. Populations who experience health disparities
  2.3.2. Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.
  2.3.3. Persons with chronic conditions
  2.3.4. Limited English Proficient (LEP) Members

2.4. The CAC is comprised of members, as follows:
  2.4.1. Alliance members
  2.4.2. Community advocates for hard-to-reach populations
  2.4.3. Safety-net provider (minimum of one)
  2.4.4. Traditional provider (minimum of one)

2.5. At least 51% of the committee are Alliance members (and/or the parents/caregivers of Alliance members who are minors or dependents).

2.6. At least one CAC member serves on the Alliance Board of Governors.

2.7. The Alliance's selection committee selects the CAC members no later than 180 calendar days from the effective date of the contract.

2.8. Should a CAC member resign, is asked to resign, or is otherwise unable to serve on the CAC, the Alliance will make its best effort to promptly replace the vacant seat within 60 calendar days of the CAC vacancy.

2.9. One member of the CAC or another Alliance member designated by the CAC will be appointed to serve as the Alliance's representative to DHCS' Statewide Community Advisory Committee.

2.10. All members complete a Confidentiality and Conflict of Interest Agreement pertaining to maintaining confidentiality of information utilized or maintained by the Alliance and the CAC member's responsibility to declare any actual or potential conflict of interest and withdraw from participation where there might be a conflict.

3. CAC Coordinator

3.1. The Alliance designates the Health Education Coordinator as the CAC Coordinator and maintains a detailed job description detailing the CAC Coordinator's responsibility to manage the operations of the CAC in compliance with all the statutory, rule, and contract requirements including but not limited to:
  3.1.1. Scheduling meetings and creating agendas with the input of CAC members.
  3.1.2. Maintaining committee membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC.
  3.1.3. Actively facilitating communications and connections between the CAC and Alliance leadership, including ensuring CAC members are informed of Alliance

decisions relevant to the work of the CAC.

3.1.4. Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAC meetings.

3.1.5. Ensuring compliance with all CAC reporting and public posting requirements.

3.1.6. The CAC coordinator is an employee of the Alliance and not a member of the CAC or member enrolled with the Alliance.

4. CAC Terms of Service and Attendance:
   4.1. The term of service for each CAC member is two (2) years.
   4.2. Committee members may serve more than one term, at the discretion of the CAC Selection Subcommittee.
   4.3. A member may be dismissed from the committee if he or she fails to attend two (2) meetings of the committee within one (1) year without an excused or approved absence.
   4.4. Members must notify the Alliance of expected absences.
   4.5. Members can request a leave of absence if needed for up to one (1) year for health or personal reasons.
   4.6. Plan members receive compensation or a stipend for each meeting attended to cover time and participation, including participation in the CAC, the Alliance Board of Governors and participation in the DHCS' Statewide Community Advisory Committee. Stipends for in-person meetings cover transportation costs for members. Members may also request and receive a childcare reimbursement.
   4.7. Members who cannot use regular transit because of a disability or disabling health conditions may request assistance from the Alliance to arrange for services from East Bay Paratransit.

5. CAC Meetings:
   5.1. Regularly scheduled CAC meetings are open to the public, and meetings are posted on the Alliance website in a centralized location 30 calendar days prior to the meeting, and no later than 72 hours prior to the meeting.
   5.2. The Alliance provides a location for CAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants, and providing accommodations to allow all individuals to attend and participate in the meetings.
   5.3. The Alliance CAC drafts written minutes of each of its meetings and the associated discussions. All minutes are posted on the Alliance website and submitted to DHCS no later than 45 calendar days after each meeting. The Alliance retains the minutes for no less than 10 years and provides them to DHCS upon request.
   5.4. The CAC Chair and Vice Chair are the Alliance's CEO's designees. The CEO does

not vote at CAC meetings.

5.5. A quorum, defined as a simple majority (50% + 1) of voting members, must be present for the CAC to vote on any matter.

5.6. The Alliance will hold its first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee and quarterly thereafter.

6. Alliance CAC Support

6.1. The Alliance will provide the following to the CAC:

6.1.1. Educate CAC members to ensure they can effectively participate in CAC meetings.

6.1.2. Support to address barriers to participation of CAC members, including childcare, transportation, flexible meeting times and formats so the highest CAC member participation is possible, convenient location, and format.

6.1.3. Sufficient resources, within budgetary limitations, to support CAC activities, member outreach, retention, and support, as well as consumer listening sessions, focus groups, and/or surveys.

6.1.4. The Alliance will provide a feedback loop to inform CAC members how their input has been incorporated into relevant policies and procedures.

6.2. The Alliance Chief Health Equity Officer participates as a non-voting member of the CAC and supports the work of the CAC through consultation and reports as needed.

7. Duties of the CAC

7.1. Provide input into annual reviews and updates to relevant policies and procedures, and in particular those affecting quality improvement and health equity.

7.1.1. CAC feedback is incorporated into the Cultural and Linguistic Services Program, the Population Heath Management Strategy and the Quality Improvement and Health Equity Program.

7.2. Identify and advocate for preventive care practices to be utilized by the Alliance.

7.3. Provide input into developing and updating cultural and linguistic policy and procedure decisions including those related to quality improvement, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. This may include advising on necessary Member or Provider targeted services, programs, and trainings.

7.4. Provide and make recommendations regarding cultural appropriateness of communications, partnerships, and services.

7.5. Review Population Needs Assessment (PNA) findings and discuss opportunities with an emphasis on Health Equity and Social Drivers of Health, and providing input in the selection of health education, cultural and linguistic and quality improvement strategies.

7.6. Provide input and advice, including, but not limited to, the following:

7.6.1. Culturally appropriate service or program design

7.6.2. The Alliance's diversity, equity, and inclusion strategy
7.6.3. Priorities for health education and outreach programs
7.6.4. Member satisfaction survey results
7.6.5. Findings of the PNA
7.6.6. Plan marketing materials and campaigns
7.6.7. Communication of needs for Network development and assessment
7.6.8. Community resources and information
7.6.9. Population health management and health equity
7.6.10. Quality Improvement, including:
7.6.10.1. Member satisfaction survey results pertinent to timely access standards
7.6.10.2. Quality improvement activities and interactions
7.6.11. Health Delivery Systems Reforms to improve health outcomes
7.6.12. Carved Out Services
7.6.13. Coordination of Care
7.6.14. Health Equity
7.6.15. Accessibility of Services

8. Annual CAC Demographic Report
8.1. The Alliance will submit an annual demographic report regarding the CAC on April 1st of each year with descriptions of the following.
8.1.1. The demographic composition of CAC membership
8.1.2. How Alliance defines the demographics and diversity of its Members and Potential Members within Alliance's Service Area
8.1.3. The data sources relied upon by the Alliance to validate that its CAC membership aligns with the Alliance's Member demographics
8.1.4. Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within Contractor's Service Area
8.1.5. Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Alliance's Service Area.
8.1.6. A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Alliance's initiatives and/or policies.

9. Reporting structure for the CAC
9.1. The CAC's activities and feedback are reported to the Cultural and Linguistic Services Subcommittee, which reports to the Quality Improvement and Health Equity Committee, a subcommittee of the Alliance Board of Governors.

DEFINITIONS / ACRONYMS

CEO: Chief Executive Officer
CHEO: Chief Health Equity Officer
BOG: Board of Governors
CAC: Community Advisory Committee
DHCS: Department of Health Care Services
Health Disparity: Differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.
Health Equity: The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Health Inequity: A systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow, live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.
FQHCs: Federally Qualified Health Centers
IHS: Indian Health Services
CAC: Community Advisory Committee
PNA: Population Needs Assessment

AFFECTED DEPARTMENTS/PARTIES

All

REVISION HISTORY

4/1/1999, 1/1/08, 9/1/09, 2/26/10, 3/11/10, 2/5/2015, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/22/2022, 3/21/2023, 12/19/2023, TBD

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Program Description
QI-101 Quality Improvement Program
QI-117 Member Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REFERENCES

DHCS Medi-Cal Contract Exhibit A, Attachment III, 5.2.11
MMCD Policy Letter 99-01
Title 28, California Code of Regulations, Section 1300.69
Title 22, California Code of Regulations, Section 53876 (c)

MONITORING

This policy will be reviewed annually to ensure effectiveness.

Updates on CAC activities and feedback are reported to the Cultural and Linguistic Services Committee, which reports to the Quality Improvement and Health Equity Committee, a subcommittee of the Alliance Board of Governors.

POLICY AND PROCEDURE

Policy Number	CLS-002
Policy Name	Community Engagement
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal and Group Care
Effective Date	4/1/1999
Subcommittee	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~11/17/2023~~TBD
Compliance Committee Approval Date	~~12/19/2023~~TBD

POLICY STATEMENT

The Alameda Alliance for Health (the Alliance) community engagement strategy ensures that members and families are partners in the delivery of covered services. The Alliance community engagement efforts encourage Alliance members and families to participate in the public policy of the health plan and the development of programs that ensure health care access and dignity for its diverse members. The structure, functions, accountability, and scope of community engagement shall be in accordance with applicable regulations and contracts.

The Alliance community engagement strategy follows applicable laws and Department of Healthcare Services mandates including Title 22 California Code of Regulations section 53876 (c), Title 28, California Code of Regulations, Section 1300.69, and the 2024 DHCS Single Plan Contract Exhibit A. ~~The Alliance Community~~

PROCEDURE

1. The Alliance community engagement strategy includes the following elements:
   1.1. Maintaining an organizational leadership commitment to engaging members and families in the delivery of care through adequate funding of resources to promote community engagement activities and support the dissemination of community engagement results.
   1.2. Quality and health equity initiatives routinely engage members and families through focus groups, listening sessions, surveys and/or interviews. The findings,

recommendations, and results are incorporated into policies and decision-making and inform interventions.

1.3. As the Alliance creates new initiatives or process updates, project leaders consider whether member and family feedback will be needed, what would be the best format, and how to incorporate the feedback into updated policies and decision-making.

1.4. Members who participate in the process will be informed of the impact of their feedback through community meetings or other forms of communication.

1.5. The Alliance maintains documentation of member feedback and results in order to ensure accountability for incorporating member and family input into policies and decision-making.

1.6. Member engagement and input is incorporated into the Quality Improvement and Health Equity Program Evaluation to measure and monitor the impact of the input. (*QI-101 Quality Improvement Program*)

1.7. The Alliance conducts member surveys and incorporates the results in quality improvement and health equity activities. (*QI-117 Member Satisfaction Survey)*

1.8. The Alliance has a Community Advisory Committee (CAC) that meets regularly to provide diverse member and family input into Alliance policies, procedures, and programs. The findings and recommendations inform Alliance activities and interventions. ~~The Member Advisory Committee (MAC) acts as the Community Advisory Committee (CAC).~~

1.9. The C~~M~~AC is comprised primarily of Alliance members, as part of the Alliance's implementation and maintenance of member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.

1.10. The Alliance partners with community-based organizations to cultivate member and family engagement.

1.11. The C~~M~~AC's input is actively utilized in policies and decision-making.

2. ~~Member~~ Community Advisory Committee Membership

2.1. The Alliance convenes a selection committee tasked with selecting the members of the C~~M~~AC. The Alliance makes a good faith effort to ensure that the C~~M~~AC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the C~~M~~AC.

2.1.1. Alliance BOG representatives including Safety Net Providers, Federally Qualified Health Centers (FQHCs), behavioral health, regional centers, local education authorities, dental Providers, Indian Health Service (IHS) Facilities, and home and community-based Providers.

2.1.2. Persons and community-based organizations who represent the diversity of Alameda County.

2.2. The Committee membership reflects the general Medi-Cal member population in Alameda County, including the following or their representatives:

2.2.1. Representatives from any Indian Health Service providers

2.2.2. Adolescents and/or parents and/or caregivers of children, including foster youth.

2.3. The make--up of the CM~~M~~AC is adjusted as the community changes to ensure the community is represented and engaged and makes a good faith effort to include representatives from diverse and hard to reach populations, with a specific emphasis on:

2.3.1. Populations who experience health disparities

2.3.2. Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

2.3.3. Persons with chronic conditions

2.3.4. Limited English Proficient (LEP) Members

2.4. The CM~~M~~AC is comprised of ~~up to 20~~ members, as follows:

2.4.1. Alliance members

2.4.2. Community advocates for hard-to-reach populations

2.4.3. Safety-net provider (minimum of one)

2.4.4. Traditional provider (minimum of one)

2.5. At least 51% of the committee are~~is~~ Alliance members (and/or the parents/caregivers of Alliance members who are minors or dependents).

2.6. At least one CM~~M~~AC member serves on the Alliance Board of Governors.

2.7. The Alliance's selection committee selects the CM~~M~~AC members no later than 180 calendar days from the effective date of the contract.

2.8. Should a CM~~M~~AC member resign, is asked to resign, or is otherwise unable to serve on the CM~~M~~AC, the Alliance will make its best effort to promptly replace the vacant seat within 60 calendar days of the CM~~M~~AC vacancy.

2.9. One member of the CM~~M~~AC or another Alliance member designated by the CM~~M~~AC will be appointed to serve as the Alliance's representative to DHCS' Statewide ~~Consumer~~ Community Advisory Committee.

2.10. All members complete a Confidentiality and Conflict of Interest Agreement pertaining to maintaining confidentiality of information utilized or maintained by the Alliance and the CM~~M~~AC member's responsibility to declare any actual or potential conflict of interest and withdraw from participation where there might be a conflict.

3. CM~~M~~AC Coordinator

3.1. The Alliance designates the Health Education Coordinator as the CM~~M~~AC Coordinator and maintains a detailed job description detailing the CM~~M~~AC Coordinator's responsibility to manage the operations of the CM~~M~~AC in compliance with all the statutory, rule, and contract requirements including but not limited to:

3.1.1. Scheduling meetings and creating agendas with the input of CM~~M~~AC members.

3.1.2. Maintaining committee membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CM~~M~~AC.

3.1.3. Actively facilitating communications and connections between the CMAC and Alliance leadership, including ensuring CMAC members are informed of Alliance decisions relevant to the work of the MACCAC.

3.1.4. Ensuring that MACCAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in MACCAC meetings.

3.1.5. Ensuring compliance with all MACCAC reporting and public posting requirements.

3.1.6. The MACCAC coordinator is an employee of the Alliance and not a member of the MACCAC or member enrolled with the Alliance.

4. MACCAC Terms of Service and Attendance:

4.1. The term of service for each Member Advisory CommitteeCAC member is twoone (21) years.

4.2. Committee members may serve more than one term, at the discretion of the Chief Executive Officer (CEO). CAC Selection Subcommittee.

4.3. A member may be dismissed from the committee if he or she fails to attend two (2) meetings of the committee within one (1) year without an excused or approved absence. for reasons other than illness.

4.4. Members must notify the Alliance of expected absences.

4.4.4.5. Members can request a leave of absence if needed for up to one (1) year for health or personal reasons.

4.5.4.6. Plan members receive compensation or a stipend for each meeting attended to cover time and participation, including participation in the MACCAC, the Alliance Board of Governors and participation in the DHCS' Statewide Consumer Community Advisory Committee. Stipends for in-person meetings cover transportation costs for members. Members may also may request and receive a childcare reimbursement.

4.6.4.7. Members who cannot use regular transit because of a disability or disabling health conditions may request assistance from the Alliance to arrange for services from East Bay Paratransit.

5. MACCAC Committee Meetings:

5.1. Regularly scheduled MACCAC meetings are open to the public, and meetings are posted on the Alliance website in a centralized location 30 calendar days prior to the meeting, and no later than 72 hours prior to the meeting.

5.2. The Alliance provides a location for MACCAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants, and providing accommodations to allow all individuals to attend and participate in the meetings.

5.3. The Alliance MACCAC drafts written minutes of each of its meetings and the

associated discussions. All minutes are posted on the Alliance website and submitted to DHCS no later than 45 calendar days after each meeting. The Alliance retains the minutes for no less than 10 years and provides them to DHCS upon request.

5.4. The ~~MAC~~CAC Chair and Vice Chair are the Alliance's CEO's designees. The CEO does not vote at ~~MAC~~CAC meetings.

5.5. A quorum, defined as a simple majority (50% + 1) of voting members, must be present for the ~~MAC~~CAC to vote on any matter.

5.6. The Alliance will hold its first regular ~~MAC~~CAC meeting promptly after all initial ~~MAC~~CAC members have been selected by the ~~MAC~~CAC selection committee and quarterly thereafter.

6. Alliance ~~MAC~~CAC Support

6.1. The Alliance will provide the following to the CAC~~Member Advisory Committee~~:

6.1.1. Educate ~~MAC~~CAC members to ensure they can effectively participate in ~~MAC~~CAC meetings.

6.1.2. Support to address barriers to participation of ~~MAC~~CAC members, including childcare, transportation, flexible meeting times and formats so the highest ~~MAC~~CAC member participation is possible, convenient location, and format.

6.1.3. Sufficient resources, within budgetary limitations, to support ~~Member Advisory Committee~~ CAC activities, member outreach, retention, and support, as well as consumer listening sessions, focus groups, and/or surveys.

6.1.4. The Alliance will provide a feedback loop to inform ~~MAC~~CAC members how their input has been incorporated into relevant policies and procedures.

6.2. The Alliance Chief Health Equity Officer participates as a non-voting member of the ~~MAC~~CAC and supports the work of the ~~MAC~~CAC through consultation and reports as needed.

7. Duties of the ~~MAC~~CAC

7.1. Provide input into annual reviews and updates to relevant policies and procedures, and in particular those affecting quality improvement and health equity.

7.1.1. ~~MAC~~CAC feedback is incorporated into the Cultural and Linguistic Services Program, the Population Heath Management Strategy and the Quality Improvement and Health Equity Program.

7.2. Identify and advocate for preventive care practices to be utilized by the Alliance.

7.3. Provide input into developing and updating cultural and linguistic policy and procedure decisions including those related to quality improvement, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. This may include advising on necessary Member or Provider targeted services, programs, and trainings.

7.4. Provide and make recommendations regarding cultural appropriateness of communications, partnerships, and services.

7.5. Review Population Needs Assessment (PNA) findings and discuss opportunities with

an emphasis on Health Equity and Social Drivers of Health, and providing input in the selection of health education, cultural and linguistic and quality improvement strategies.

7.6. Provide input and advice, including, but not limited to, the following:
- 7.6.1. Culturally appropriate service or program design
- 7.6.2. The Alliance's diversity, equity, and inclusion strategy
- 7.6.3. Priorities for health education and outreach programs
- 7.6.4. Member satisfaction survey results
- 7.6.5. Findings of the PNA
- 7.6.6. Plan marketing materials and campaigns
- 7.6.7. Communication of needs for Network development and assessment
- 7.6.8. Community resources and information
- 7.6.9. Population health management and health equity
- 7.6.10. Quality Improvement, including:
  - 7.6.10.1. Member satisfaction survey results pertinent to timely access standards
  - 7.6.10.2. Quality improvement activities and interactions
- 7.6.11. Health Delivery Systems Reforms to improve health outcomes
- 7.6.12. Carved Out Services
- 7.6.13. Coordination of Care
- 7.6.14. Health Equity
- 7.6.15. Accessibility of Services

8. Annual ~~MAC~~CAC Demographic Report

8.1. The Alliance will submit an annual demographic report regarding the ~~MAC~~CAC on April 1st of each year with descriptions of the following.
- 8.1.1. The demographic composition of ~~MAC~~CAC membership
- 8.1.2. How Alliance defines the demographics and diversity of its Members and Potential Members within Alliance's Service Area
- 8.1.3. The data sources relied upon by the Alliance to validate that its ~~MAC~~CAC membership aligns with the Alliance's Member demographics
- 8.1.4. Barriers to and challenges in meeting or increasing alignment between ~~MAC~~CAC's membership with the demographics of the Members within Contractor's Service Area
- 8.1.5. Ongoing, updated, and new efforts and strategies undertaken in ~~MAC~~CAC membership recruitment to address the barriers and challenges to achieving alignment between ~~MAC~~CAC membership with the demographics of the Members within Alliance's Service Area.
- 8.1.6. A description of the ~~MAC~~CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how ~~MAC~~CAC input impacted and shaped Alliance's initiatives and/or policies.

9. Reporting structure for the ~~MAC~~CAC
   9.1. The ~~MAC~~CAC's activities and feedback are reported to the Cultural and Linguistic Services Subc~~C~~ommittee, which reports to the Quality Improvement and Health Equity Committee, a subcommittee of the Alliance Board of Governors.

DEFINITIONS / ACRONYMS

CEO:~~—~~ Chief Executive Officer
CHEO: ~~—~~Chief Health Equity Officer
BOG: ~~—~~Board of Governors
CAC: ~~—~~Community Advisory Committee
DHCS: ~~—~~Department of Health ~~e~~Care Services
Health Disparity: ~~—~~Differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.
Health Equity: ~~—~~The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Health Inequity:~~—~~ A systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow, live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.
FQHCs: ~~—~~Federally Qualified Health Centers
IHS: ~~—~~Indian Health Services
~~MAC~~CAC: ~~—Member~~Community Advisory Committee
PNA: ~~—~~Population Needs Assessment

AFFECTED DEPARTMENTS/PARTIES

All

REVISION HISTORY

4/1/1999, 1/1/08, 9/1/09, 2/26/10, 3/11/10, 2/5/2015, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/22/2022, 3/21/2023, 12/19/2023, TBD

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Program Description
QI-101 Quality Improvement Program
QI-117 Member Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REFERENCES

DHCS Medi-Cal Contract Exhibit A, Attachment III, 5.2.11
MMCD Policy Letter 99-01
Title 28, California Code of Regulations, Section 1300.69
Title 22, California Code of Regulations, Section 53876 (c)

MONITORING

This policy will be reviewed annually to ensure effectiveness.

Updates on ~~MAC~~CAC activities and feedback are reported to the Cultural and Linguistic Services Committee, which reports to the Quality Improvement and Health Equity Committee, a subcommittee of the Alliance Board of Governors.

POLICY AND PROCEDURE

Policy Number	CLS-003
Policy Name	Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal and Group Care
Effective Date	7/01/1998
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health offers language assistance services to monolingual, non-English-speaking or limited English proficiency (LEP) members and potential members and effective communication for members with disabilities at no charge. The Alliance has processes in place to effectively identify LEP member language assistance needs at all points of contact, to inform Alliance members and members with disabilities of available language assistance services, including interpretation, telephone language services, translation, and alternate formats, or legally compliant electronic options, to facilitate member's access to language services and effective communication and ensure the timeliness and quality of the services. The Alliance also has processes in place to abide by its regulatory and contractual standards related to providing language services to its members. Regulatory standards that inform the Language Assistance Services at the Alliance are listed in the "Reference section" below.

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PROCEDURE

1. **Member Identification.** The Alliance identifies members who need interpreter services through the following methods:
   1.1. Uploading enrollment data each month (or more frequently if available) into our data and contact management systems. Data includes member ethnicity and preferred language.
      1.1.1. Alliance staff can view language preferences and ethnicity in our data contact management systems.
      1.1.2. The Alliance network of providers can view the language preferences of members in the provider portal.
      1.1.3. Automated voice systems respond to member phone calls to the Alliance in identified threshold languages and connect the member with bilingual Alliance staff if available or staff will contact our interpreter vendor for assistance.
   1.2. Alliance staff updates member preferred language information in contact management systems as new preferences are communicated.
   1.3. Providers document member's preferred language in the member's medical record.
   1.4. The Alliance maintains a list of non-English languages likely to be encountered. This membership report is updated monthly by the Health Care Analytics Department and reviewed quarterly by the Cultural and Linguistic Services Subcommittee.

2. **Interpreter Access.** Interpreter services are offered at no cost to Alliance members at all points of contact both medical and non-medical care, including, but not limited to telephone, advice and urgent care transactions, outpatient encounters with providers, Member Services, new member orientations, and appointment scheduling. Interpretation services are available 24-hours a day, 7 days a week, so member's timely access to care will not be delayed due to any lack of interpreter services. The Alliance assures timely delivery of no cost interpretation services in the following ways:
   2.1. Oral Interpreters, sign language interpreters or bilingual providers are provided in all languages spoken by members and potential Members, not limited to threshold or concentration languages.
   2.2. Members who call or visit the Alliance during Alliance business hours, Monday – Friday, 8 am – 5 pm, except for holidays, seeking assistance in a non-English language:
      2.2.1. Member calls are routed by Alliance threshold languages to a bilingual staff member or a staff-person who will use the Alliance interpreter vendors to speak with the member in their language.
      2.2.2. Members who visit the Alliance offices will be assessed by the reception staff using the "Point to Your Language" poster. A staff-person who speaks the member's language will be called, or a staff person will call the Alliance interpreter vendor for language assistance.
   2.3. Members can access no cost interpreter services for routine and urgent health care

appointments, when accessing emergency services or after hours.

2.3.1. Language needs may be met through Alliance providers, i.e. providers with qualified bilingual staff, hospital, or clinic interpreter services.

2.3.2. If an Alliance provider cannot meet the language need of a member, or for after- hours interpreter services, the provider can call the Alliance interpreter service vendor directly to receive telephonic interpreter services.

2.3.3. Some providers have capacity to offer video remote interpreting services (VRI). These services must comply with federal quality standards.

2.3.4. Members can call Member Services and receive interpreter services.

3. The Alliance coordinates interpreter services at the time of appointment scheduling. Members needing interpreter services for a future health care appointment:

3.1. May call Alliance Member Services to request assistance with arranging for an interpreter for their future appointment.

3.1.1. If the request is at least 5 business days advanced notice, the Alliance Member Services contacts the provider and asks them to submit an *Interpreter Services Request Form* to the Alliance to request an interpreter or use Alliance's 24/7 telephonic interpreter services. In-person requests must meet current guidelines.

3.1.2. If less than 5 business days-notice, Alliance Member Services staff contacts provider and provides education on accessing telephonic interpretation through Alliance interpreter services vendor, or as last resort, reschedules the appointment.

3.2. May call the provider to request an interpreter for their appointment. Providers will offer interpreter services to members with non-English language preferences. These services may be provided by:

3.2.1. A qualified bilingual staff or interpreter at the health care provider office

3.2.2. The Alliance 24/7 telephonic interpreter service

3.2.3. Providers can fax a request to the Alliance to schedule in-person or prescheduled telephonic/video interpreters.

3.3. In-person interpreters are available for American Sign Language (ASL), complex, highly sensitive visits, or other circumstances upon approval by Alliance.

3.4. When interpreter requests for in-person interpretation are made with less than 5 business days' notice, the provider or member may be asked to use a telephonic interpreter for the appointment (except for ASL interpreters) or reschedule only if no in-person interpreter can be arranged.

3.5. ASL interpreter requests cannot be arranged with a telephonic interpreter. When an ASL interpreter cannot be arranged in advance, providers may use the California Relay Service (CRS) to contact deaf or hard of hearing members by phone, if other services are not available in the office.

4. Alliance staff document refusal of interpreter services or member's language preferences in the Alliance data management systems and Alliance health care providers document in the

member's medical record.

5. The Alliance assures timely delivery of language assistance services through performance monitoring of interpreter services coordination, provision of telephone and video interpreting (where available) and scheduling in-person interpreter services for future appointments. See *CLS -011 Compliance Monitoring of C & L Program* for details.

6. The Alliance ensures that individuals who provide language interpretation services for Alliance members are qualified.
   6.1. Qualified interpreters:
      6.1.1. Are proficient in English and the relevant interpreted language,
      6.1.2. Can interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP individual and English, using any necessary specialized vocabulary, terminology, and phraseology.
      6.1.3. Comply with the ethical principles, protocols including client confidentiality.
   6.2. These standards are included in the vendor contracting language.
   6.3. See *CLS-010 CLS Staff Training* for additional details on Alliance bilingual staff assessment.
   6.4. See *CLS-009 CLS Program - Contracted Providers* for details on documenting qualifications of bilingual providers.

7. Remote audio interpreting services offered by the Alliance provide real-time audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality audio without lags or irregular pauses, clear, audible transmission of voices and adequate training to users of the technology so they can easily use the remote interpreting services.

8. **Translation**. The Alliance provides members written informing materials in the Alliance threshold languages based on the Member's language of preference.
   8.1. LEP members that speak the identified threshold or concentration standard languages have full and immediate translation of written informing materials as defined in 42 CFR sections 438.10(d)(3), 438.404, and 438.408; W&I Code 14029.91; 22 CCR sections 53876 and 53884 10. The threshold or concentration languages are identified by DHCS within the Alliance's Service Area, and by the Alliance through membership assessments. See *CLS-008 Member Assessment* for more details.
   8.2. Translations are produced by qualified translators who:
      8.2.1. Adhere to generally accepted translator ethics principles, including client confidentiality
      8.2.2. Have demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation
   8.3. Can translate effectively, accurately, and impartially to and from such language(s) and

English, using any necessary specialized vocabulary, terminology, and phraseology

8.4. Member Informing materials, also known as vital documents, include but are not limited to

8.4.1. Member Handbook (Evidence of Coverage)
8.4.2. Provider Directory
8.4.3. new member welcome packets
8.4.4. marketing information
8.4.5. member rights information
8.4.6. form letters and individual notices including notice of action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and other letters containing important information regarding eligibility and participation criteria
8.4.7. applications, consent forms,
8.4.8. notices advising LEP members of the availability of at no cost language assistance, and
8.4.9. documents that require a response by the member
8.4.10. and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004

8.5. Non-threshold language translations of informing materials are available upon request. The Alliance will provide the translation in 21 days or less from the date of request. If a vital document is not standardized, but contains member's specific information, a written notice of the availability of interpretation services is included with the documents.

8.6. Alliance departments initiates member communication work with the Communications and Outreach Department and our translation vendor to create quality translations and refer to the Alliance data systems or the Health Care Analytics Department to identify members' language and alternate format preferences.

8.6.1. All translated materials will abide by the English version approved by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) or the qualified plan Health Educator (for health education materials only).

8.6.2. The Alliance Communications and Outreach Department maintains files with an English version of all translated member informing and health education documents an attestation as to the accuracy of the translation. The Alliance translation vendor also provides attestations for translated member communications with member-specific language. Policy and procedure *C&O-001 Community Relations and Outreach Activities* describes the plan's translation process.

8.7. Member Services staff are also available to assist non-English speaking members in understanding information in Alliance documents. Bilingual staff will read relevant documents to the member, staff will use our interpreter service to interpret the document, or staff will request a translation of the document for the member.

9. **Community Services Program Referrals.** The Alliance maintains referral lists of culturally and linguistically appropriate community services programs. Members are informed of available programs through contact with the Member Services and Population Health and Equity Departments and member newsletters. Providers are informed of available programs

at least annually through provider visits and through the Alliance provider website.

10. **Effective Communication with Individuals with Disabilities**. The Alliance takes steps to ensure effective communication with members with disabilities, including persons with impaired sensory, manual, or speaking skills. This includes Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including ASL interpreters, and information in alternative formats including Braille, audio format, large print (no less than 20 point Ariel font), and accessible electronic format, such as data CD, as well as requests for other auxiliary aids and services that may be appropriate.
    10.1. The Alliance provides telecommunication access for deaf or hard of hearing members (TDD) through TTY/California Relay System (CRS) numbers listed on member communications, in the Member Handbook (Evidence of Coverage) and newsletters. All member facing staff are trained on the use of CRS.
    10.2. The Alliance provides members with alternative formats of Alliance written materials and auxiliary aids and services upon request. Auxiliary aids are also available to Alliance members' authorized representatives or someone with whom it is appropriate for the Alliance to communicate, including a family member, friend, or associate involved in the member's healthcare.
    10.3. Alternative format requests may include Braille, audio format, large print (no less than 20-point Arial font), and other electronic formats, such as a data CD.
        10.3.1. Members contact Alliance Member Services to request alternative formats of member materials. See P&P *C&O-001 Community Relations and Outreach Activities* for details. Requests are sent to the Alliance Communications and Outreach Department and the requested format is distributed to the member.
        10.3.2. The Alliance collects and stores the alternative format request in main data systems for use when sending member communications and to share with DHCS. Included is the following information:
            - Beneficiary Client Index Number
            - Name
            - Date of request
            - Requested alternative format
    10.4. Members or someone with whom it is appropriate for the Alliance to communicate can request auxiliary aids and services by calling Member Services. Member Services will connect the individual to Alliance Case Management who will offer health navigation support to receive the needed auxiliary aids and services.

11. **Quality of Interpreter Services**. When providing interpreting services to members with disabilities, the interpreter must meet the qualifications described previously in this document. Qualified interpreters may include ASL interpreters, oral transliterators, or cued language transliterators. Any interpreter for members with disabilities provided through VRI must have high quality images with display able to accommodate the interpreter's and participating individual's face, arms, hands and fingers, and meet VRI requirements

described previously in this document.

11.1. As with other language interpreters, the Alliance does not require members with disabilities to bring their own interpreter and does not rely on adult or minor children to accompany an individual except as listed below.

12. **Informing Members.** The Alliance informs members, including members with disabilities, and providers of the availability of language services at no cost, including interpreters for LEP members, ASL interpreters, written translation, availability of alternative formats, auxiliary aids and services, and access for the deaf or hard of hearing through multiple methods.

12.1. The Alliance does not rely on the use of the member's family, friends, or unqualified staff as interpreters.

12.1.1. Providers are educated on the risks of using unqualified interpreters.

12.1.2. Adult or minor children should not interpret except in cases of emergency where there is imminent threat to the safety and welfare of the person, or the public, and a qualified interpreter is not available or the LEP member specifically requests that an accompanying adult interprets, the adult agrees to assist and relying on that adult is appropriate under the circumstances.

12.1.3. Providers must inform members of their right to qualified interpreter services and document the refusal in the patient's medical record.

12.2. Members are informed of their right to language services at no cost, alternative formats and auxiliary aids in the New Member Welcome packet, the Member Handbook, the Alliance member website, member newsletters, non-discrimination notices sent out with member informing communications and when communicating with Alliance staff.

12.3. Providers are informed of how to access the plan's language services at no cost and are educated on how to use the interpreter services, alternative formats, and auxiliary aids and services through the New Provider Orientation, provider site visits, Alliance provider website and the Provider Manual.

13. Nondiscrimination Notice.

13.1. The Alliance posts a nondiscrimination notice that informs members, potential enrollees and the public about nondiscrimination, protected characteristics, and accessibility requirements and the Alliance's compliance with those requirements. The Notice of Non-Discrimination includes the seven (7) required elements as contained in the sample nondiscrimination notice.

13.2. The notice is posted in at least 12-point font size and is included in the Member Handbook, member information and all other information notices targeted to members, potential enrollees, and the public. (Except those that are small-sized, see below).

13.3. This notice is included as well in outreach, education, and marketing materials as well as notices that require a response or that pertain to the member's rights and

benefits.

13.4. The notice is also posted in conspicuous physical locations where the Alliance interacts with the public, as well as on the Alliance website in an easily found location.

13.5. The nondiscrimination notice includes all legally required elements as well as information on how to file discrimination grievances with DHCS Office of Civil Rights (OCR), and with the plan, as is described in the DHCS nondiscrimination notice template.

14. Discrimination Grievances

14.1. The Alliance has a grievance process in place with the capacity to capture grievances in the language spoken by the member.

14.2. Upon enrollment, Alliance Members are informed of the Plan's grievance and appeals process and are offered forms for filing grievance and appeals. These forms are available in the Alliance threshold languages and are available upon request.

14.3. Additionally, the Alliance ensures all members can participate in its grievance system by providing assistance to LEP Members or with a visual or other communicative impairment.

14.4. The Alliance has a designated discrimination grievance coordinator responsible for ensuring compliance with both federal and state nondiscrimination requirements, including compliance with Section 1557 of the Patient Protection and Affordable Care Act (ACA).

15. Language Assistance Taglines. The Alliance ensures members are aware of language assistance availability through use of Taglines.

15.1. The Alliance posts taglines in at least 12-point font in English and at least the top California languages.

15.2. Current languages in the taglines include the top 15 non-English languages spoken by LEP individuals in California, as identified by HHS OCR in 2016, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese as well as Laotian, Ukrainian and Mien which are used in Medi-Cal Fee for Service (FFS).

15.3. The taglines inform members, potential members, and the public of the availability of no-cost language assistance services including assistance in non-English languages and the provision of free auxiliary aids and services for people with disabilities.

15.3.1. Taglines are posted with in the Member Handbook, conspicuous locations and in all member information and other information notices.

16. **Access for Persons with Disabilities.** The Alliance ensures access for persons with disabilities in compliance with the requirements of Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405.

16.1. Offering qualified interpreters when oral interpretation is a reasonable step to provide meaningful access.

16.2. Using qualified translators for written translation.

16.3. Offering free, accurate, timely and confidential language services (Sections 3-5)

16.4. Ensuring access for individuals with disabilities, including accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces and accessible drinking water. Accessibility is monitored through the Alliance's physical accessibility review surveys. See Policy and Procedure *QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Survey (PARS)* for details.

16.5. Providing auxiliary aids and services to individuals with disabilities.

16.6. Making reasonable changes to policies, practices, and procedures to provide equal access for members with disabilities. Policies and procedures are reviewed annually by all internal departments to ensure there are no barriers for members to access care.

DEFINITIONS / ACRONYMS

ACA: Affordable Care Act
ASL: American Sign Language
CLS: Cultural and Linguistic Services
Alternative Format: Formats such as Braille, audio format, large print (no less than 20 point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate
Auxiliary Aids: Devices used by persons with disabilities for communication, such as Telephone Typewriters (TTY) or Telecommunication Devices for the Deaf (TDD).**OCR**: Office of Civil Rights
FFS: Fee for Service

CRS – California Relay Services
Cued language transliterators - Individuals who represent or spell by using a small number of handshapes.
Interpretation services include: (1) availability of trained bilingual plan and provider staff (2) hiring staff interpreters (3) contracting with an outside interpreter service for qualified interpreters (4) arranging for the services of voluntary, qualified community interpreters (5) contracting for telephone, videoconferencing, or other telecommunication supported interpretation services.
Interpreter - An interpreter is a person who renders a message spoken in one language into one or more languages.
LEP – Limited English Proficient
Oral transliterators – Individuals who represent or spell in characters of another alphabet.
TDD – Telecommunications Devices for Deaf
Translation – Translation is the replacement of written text from one language into another.
TTY – (Teletypewriter) is a communication device used by people who are deaf, hard-of-hearing, or have severe speech impairment.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Provider Network

COMPLIANCE COMMITTEE REVISION HISTORY

7/1/1998, 11/1/04, 1/1/08, 9/29/09, 2/26/10, 3/13/12, 4/13/2015, 3/24/2016, 11/10/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, TBD

RELATED POLICIES AND PROCEDURES

CLS-008	Member Assessment of Cultural and Linguistic Needs
CLS-009	CLS Program - Contracted Providers
CLS-010	CLS Program - Staff Training
CLS-011	Compliance Monitoring of C & L Program
C&O-001	Community Relations and Outreach Activities
QI-105	Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical

Accessibility Review Survey (PARS)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

Americans with Disabilities Act of 1990
CFR, Part 42 Sections 438.10(d), 439.10, 438.404 and 438.408
DHCS All Plan Letter 21-004
DHCS All Plan Letter 22-002
DHCS Exhibit A, contract Attachments 9, Sections 13 and 14
Government Code Sections 11135 and 7405
2024 DHCS Exhibit A Attachment III Section 5.2.10 Access Rights
Patient Protection and Affordable Care Act, Section 1557
Title VI, Civil Rights Act of 1964
Title 22, CCR, Sections 51202.5 and 51309.5(a), 53853(c), 53876, and 53884
Title 28, CCR sections 1300.67.04(c)(2)(A)-(B) and 1300.67.04 (c) (2)(G)(v) – (c) (4)
Rehabilitation Act of 1973, Sections 504 and 508
SB 223 Health Care Language Assistance Services
SB 1423 Oral Interpretation Services
W&I Code 14029.91

MONITORING

This policy will be reviewed annually to ensure effectiveness.

POLICY AND PROCEDURE

Policy Number	CLS-003
Policy Name	Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal and Group Care
Effective Date	7/01/1998
Subcommittee Name	Quality Improvement Health Equity ~~Care Quality~~ Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	~~3/21/2023~~TBD

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POLICY STATEMENT

Alameda Alliance for Health offers language assistance services to monolingual, non-English-speaking or l~~L~~imited English p~~P~~roficiency (LEP) members and potential members and effective communication for members with disabilities at no charge. The Alliance has processes in place to effectively identify ~~Limited English Proficiency (~~LEP~~)~~ member language assistance needs at all points of contact, to inform Alliance members and members with disabilities of available language assistance services, including interpretation, telephone language services, translation, and alternate formats, or legally compliant electronic options, to facilitate member's access to language services and effective communication and ensure the timeliness and quality of the services. The Alliance also has processes in place to abide by its regulatory and contractual standards related to providing language services to its members. Regulatory standards that inform the Language Assistance Services at the Alliance are listed in the "Reference section" below.

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PROCEDURE

1. **Member Identification.** The Alliance identifies members who need interpreter services through the following methods:

1.1. Uploading enrollment data each month (or more frequently if available) into our data and contact management systems. Data includes member ethnicity and preferred language.
  1.1.1. Alliance staff can view language preferences and ethnicity in our data contact management systems.
  1.1.2. The Alliance network of providers can view the language preferences of members in the provider portal.
  1.1.3. Automated voice systems respond to member phone calls to the Alliance in identified threshold languages and connect the member with bilingual Alliance staff if available or staff will contact our interpreter vendor for assistance.
1.2. Alliance staff updates member preferred language information in contact management systems as new preferences are communicated.
1.3. Providers document member's preferred language in the member's medical record.
1.4. The Alliance maintains a list of non-English languages likely to be encountered. This membership report is updated monthly by the Health Care Analytics Department and reviewed quarterly by the Cultural and Linguistic Services Subcommittee.

2. **Interpreter A~~a~~ccess.** Interpreter services are offered at no cost to Alliance members at all points of contact both medical and non-medical care, including, but not limited to telephone, advice and urgent care transactions, outpatient encounters with providers, Member Services, new member orientations, and appointment scheduling. Interpretation services are available 24-hours a day, 7 days a week, so member's timely access to care will not be delayed due to any lack of interpreter services. The Alliance assures timely delivery of no cost interpretation services in the following ways:
2.1. Oral Interpreters, sign language interpreters or bilingual providers are provided in all languages spoken by members and potential Members, not limited to threshold or concentration languages.
2.2. Members who call or visit the Alliance during Alliance business hours, Monday – Friday, 8 am – 5 pm, except for holidays, seeking assistance in a non-English language:
  2.2.1. Member calls are routed by Alliance threshold languages to a bilingual staff member or a staff-person who will use the Alliance interpreter vendors to speak with the member in their language.
  2.2.2. Members who visit the Alliance offices will be assessed by the reception staff using the "Point to Your Language" poster. A staff-person who speaks the member's language will be called, or a staff person will call the Alliance interpreter vendor for language assistance.
2.3. Members can access ~~free~~ no cost interpreter services for~~at~~ routine and urgent health care appointments, when accessing emergency services or after hours.
  2.3.1. Language needs may be met through Alliance providers, i.e. providers with qualified bilingual staff, hospital, or clinic interpreter services.
  2.3.2. If an Alliance provider cannot meet the language need of a member, or for after- hours interpreter services, the provider can call the Alliance interpreter

service vendor directly to receive telephonic interpreter services.

2.3.3. Some providers have capacity to offer video remote interpreting services (VRI). These services must comply with federal quality standards.

2.3.4. Members can call Member Services and receive interpreter services.

3. The Alliance coordinates interpreter services at the time of appointment scheduling. Members needing interpreter services~~ation~~ for a future health care appointment:

3.1. May call Alliance Member Services to request assistance with arranging for an interpreter for their future appointment.

3.1.1. If the request is at least 5 business days advanced notice, the Alliance Member Services contacts the provider and asks them to submit an *Interpreter Services Request Form* to the Alliance to request an interpreter or use Alliance's 24/7 telephonic interpreter services. In-person requests must meet current guidelines.

3.1.2. If less than 5 business days-notice, Alliance Member Services staff contacts provider and provides education on accessing telephonic interpretation through Alliance interpreter services vendor, or as last resort, reschedules the appointment.

3.2. May call the provider to request an interpreter for their appointment. Providers will offer interpreter services to members with non-English language preferences. These services may be provided by:

3.2.1. A qualified bilingual staff or interpreter at the health care provider office

3.2.2. The Alliance 24/7 telephonic interpreter service

3.2.3. Providers can fax a request to the Alliance to schedule in-person or prescheduled telephonic/video interpreters.

3.3. In-person interpreters are available for American Sign Language (ASL), complex, highly sensitive visits, or other circumstances upon approval by Alliance ~~staff~~.

3.4. When interpreter requests for in-person interpretation are made with less than 5 business days' notice, the provider or member may be asked to use a telephonic interpreter for the appointment (except for ~~American Sign Language~~ASL interpreters) or reschedule only if no in-person interpreter can be arranged.

3.5. A~~merican~~ S~~ign~~ L~~anguage~~ interpreter requests cannot be arranged with a telephonic interpreter. When an ASL interpreter cannot be arranged ~~for~~ in advance, providers may use the California Relay Service (CRS) to contact deaf or hard of hearing ~~impaired~~ members by phone, if other services ~~for the hearing impaired~~ are not available in the office.

4. Alliance staff document refusal of interpreter services or member's language preferences in the Alliance data management systems and Alliance health care providers document in the member's medical record.

5. The Alliance assures timely delivery of language assistance services through performance monitoring of interpreter services coordination, provision of telephone and video interpreting (where available) and scheduling in-person interpreter services for future appointments. See *CLS -011 Compliance Monitoring of C & L Program* for details.

6. The Alliance ensures that individuals who provide language interpretation services for Alliance members are qualified.
   6.1. Qualified interpreters:
      6.1.1. Are proficient in English and the relevant interpreted language,
      6.1.2. Can interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP individual and English, using any necessary specialized vocabulary, terminology, and phraseology.
      6.1.3. Comply with the ethical principles, protocols including client confidentiality.
   6.2. These standards are included in the vendor contracting language.
   6.3. See *CLS-010 CLS Staff Training* for additional details on Alliance bilingual staff assessment.
   6.4. See *CLS-009 CLS Program - Contracted Providers* for details on documenting qualifications of bilingual providers.

7. Remote audio interpreting services offered by the Alliance provide real-time audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality audio without lags or irregular pauses, clear, audible transmission of voices and adequate training to users of the technology so they can easily use the remote interpreting services.

8. **Translation**. The Alliance provides members written informing materials in the Alliance threshold languages based on the Member's language of preference.
   8.1. LEP members that speak the identified threshold or concentration standard languages have full and immediate translation of written informing materials as defined in 42 CFR sections 438.10(d)(3), 438.404, and 438.408; W&I Code 14029.91; 22 CCR sections 53876 and 53884 10. The threshold or concentration languages are identified by DHCS within the Alliance's Service Area, and by the Alliance through membership assessments. See *CLS-008 Member Assessment* for more details.
   8.2. Translations are produced by qualified translators who:
      8.2.1. Adhere to generally accepted translator ethics principles, including client confidentiality
      8.2.2. Have demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation
   8.3. Can translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology
   8.4. Member Informing materials, also known as vital documents, include but are not limited to
      8.4.1. Member Handbook (Evidence of Coverage)
      8.4.2. Provider Directory
      8.4.3. new member welcome packets
      8.4.4. marketing information

8.4.5. member rights information
8.4.6. form letters and individual notices including notice of action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and other letters containing important information regarding eligibility and participation criteria
8.4.7. applications, consent forms,
8.4.8. notices advising ~~limited English proficient (~~LEP~~)~~ members of the availability of at no cost~~free~~ language assistance, and
8.4.9. documents that require a response by the member
8.4.10. and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004

8.5. Non-threshold language translations of informing materials are available upon request. The Alliance will provide the translation in 21 days or less from the date of request. If a vital document is not standardized, but contains member's specific information, a written notice of the availability of interpretation services is included with the documents.

8.6. Alliance departments initiat~~e~~s~~ing~~ member communication work with the Communications and Outreach Department and our translation vendor to create quality translations and refer to the Alliance data systems or the Health Care Analytics Department to identify members' language and alternate format preferences.

8.6.1. All translated materials will abide by the English version approved by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) or the qualified plan Health Educator (for health education materials only).

8.6.2. The Alliance Communications and Outreach Department maintains files with an English version of all translated member informing and health education documents an attestation as to the accuracy of the translation. The Alliance translation vendor also provides attestations for translated member communications with member-specific language. Policy and procedure *C&O-001 Community Relations and Outreach Activities* describes the plan's translation process.

8.7. Member Services staff are also available to assist non-English speaking members in understanding information in Alliance documents. Bilingual staff will read relevant documents to the member, staff will use our interpreter service to interpret the document, or staff will request a translation of the document for the member.

9. **Community Services Program Referrals.** The Alliance maintains referral lists of culturally and linguistically appropriate community services programs. Members are informed of available programs through contact with the Member Services and ~~Health Education~~Population Health and Equity Departments and member newsletters. Providers are informed of available programs at least annually through provider visits and through the Alliance provider website ~~provider page~~.

10. **Effective Communication with Individuals with Disabilities**. The Alliance takes steps to ensure effective communication with members with disabilities, including persons with impaired sensory, manual, or speaking skills. This includes Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including A~~merican~~ S~~ign~~ L~~anguage~~ interpreters, and information in alternative formats including Braille, audio format, large print ~~text~~ (no less than 20 point Ariel font~~20 point font or larger~~), ~~audio,~~ and accessible electronic format~~s~~, such as data CD, as well as requests for other auxiliary aids and services that may be appropriate. ~~.~~

    10.1. The Alliance provides telecommunication access for deaf or h~~dea~~ard of hearing members (TDD) through TTY/California Relay System (CRS) numbers listed on member communications, in the Member Handbook (Evidence of Coverage) and newsletters. All member facing staff are trained on the use of CRS.

    10.2. The Alliance provides members with alternative~~e~~ formats of Alliance written materials and auxiliary aids and services upon request. Auxiliary aids are also available to Alliance members' authorized representatives or someone with whom it is appropriate for the Alliance to communicate, including a family member, friend, or associate involved in the member's healthcare.

    10.3. Alternative format requests may include Braille, audio format, large print (no less than ~~10.3.~~ 20-point Arial font), and ~~accessible~~ other electronic formats, such as a data CD.

        10.3.1. Members contact Alliance Member Services to request alternative formats of member materials. See P&P *C&O-001 Community Relations and Outreach Activities* for details. Requests are sent to the Alliance Communications and Outreach Department and the requested format is distributed to the member.

        10.3.2. The Alliance collects and stores the alternative~~e~~ format request in main data systems for use when sending member communications and to share with DHCS. Included is the following information:

            - Beneficiary Client Index Number
            - Name
            - Date of request
            - Requested alternative format

    10.4. Members or someone with whom it is appropriate for the Alliance to communicate can request auxiliary aids and services by calling Member Services. Member Services will connect the individual to Alliance Case Management who will offer health navigation support to receive the needed auxiliary aids and services.

11. **Quality of Interpreter Services**. When providing interpreting~~ve~~ services to members with disabilities, the interpreter must meet the qualifications described previously in this document. Qualified interpreters may include ~~sign language~~ASL interpreters, oral transliterators, or cued language transliterators. Any interpreter for members with disabilities

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provided through VRI must have high quality images with display able to accommodate the interpreter's and participating individual's face, arms, hands and fingers, and meet VRI requirements described previously in this document.

11.1. As with other language interpreters, the Alliance does not require members with disabilities to bring their own interpreter and does not rely on adult or minor children to accompany an individual except as listed below.

12. **Informing Members.** The Alliance informs members, including members with disabilities, and providers of the availability of ~~free~~ language services at no cost, including interpreters for LEP members, A~~merican~~ S~~ign~~ L~~anguage~~ interpreters, written translation, availability of alternative~~e~~ formats, auxiliary aids and services, and access for the d~~D~~eaf or~~and~~ hard of hearing through multiple methods.

12.1. The Alliance does not rely on the use of the member's family, friends, or unqualified staff as interpreters.

12.1.1. Providers are educated on the risks of using unqualified interpreters.

12.1.2. Adult or minor children should not interpret except in cases of emergency where there is imminent threat to the safety and welfare of the person, or the public, and a qualified interpreter is not available or the LEP member specifically requests that an accompanying adult interprets, the adult agrees to assist and relying on that adult is appropriate under the circumstances.

12.1.3. Providers must inform members of their right to qualified interpreter services and document the refusal in the patient's medical record.

12.2. Members are informed of their right to ~~free~~ language services at no cost, alternative~~e~~ formats and auxiliary aids in the New Member Welcome packet, the Member Handbook, ~~member pages of~~ the Alliance member website, member newsletters, non-discrimination notices sent out with member informing communications and when communicating with Alliance staff.

12.3. Providers are informed of how to access the plan's ~~free~~ language services at no cost and are educated on how to use the interpreter services, alternative formats, and auxiliary aids and services through the New Provider Orientation, provider site visits, ~~provider information on the~~ Alliance provider website and the Provider Manual.

13. Nondiscrimination N~~n~~otice~~s~~.

13.1. The Alliance posts a nondiscrimination notice that informs members, potential enrollees and the public about nondiscrimination, protected characteristics, and accessibility requirements and the Alliance's compliance with those requirements. The Notice of Non-Discrimination includes the seven (7) required elements as contained in the sample nondiscrimination notice.

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13.2. The notice is posted in at least 12-point font size and is included in the Member Handbook, member information and all other information notices targeted to members, potential enrollees, and the public. (Except those that are small-sized, see below).

13.3. This notice is included as well in outreach, education, and marketing materials as well as notices that require a response or that pertain to the member's rights and benefits.

13.4. The notice is also posted in conspicuous physical locations where the Alliance interacts with the public, as well as on the Alliance website in an easily found location.

13.5. The nondiscrimination notice includes all legally required elements as well as information on how to file discrimination grievances with DHCS Office of Civil Rights (OCR), and with the plan, as is described in the DHCS nondiscrimination notice template.

14. Discrimination Grievances

14.1. The Alliance has a grievance process in place with the capacity to capture grievances in the language spoken by the member.

14.2. Upon enrollment, Alliance Members are informed of the Plan's grievance and appeals process and are offered forms for filing grievance and appeals. These forms are available in the Alliance threshold languages and are available upon request.

14.3. Additionally, the Alliance ensures all members can participate in its grievance system by providing assistance to LEP Members ~~with limited English proficiency~~ or with a visual or other communicative impairment.

14.4. The Alliance has a designated discrimination grievance coordinator responsible for ensuring compliance with both federal and state nondiscrimination requirements, including compliance with Section 1557 of the Patient Protection and Affordable Care Act (ACA).

15. Language Assistance Taglines. The Alliance ensures members are aware of language assistance availability through use of Taglines.

15.1. The Alliance posts taglines in at least 12-point font in English and at least the top California languages.

15.2. Current languages in the taglines include the top 15 non-English languages spoken by LEP individuals in California, as identified by HHS OCR in 2016, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese as well as Laotian, Ukrainian and Mien which are used in Medi-Cal Fee for Service (FFS).

15.3. The taglines inform members, potential members, and the public of the availability of no-cost language assistance services including assistance in non-English languages and the provision of free auxiliary aids and services for people with disabilities.

15.3.1. Taglines are posted with in the Member Handbook, conspicuous locations and in all member information and other information notices.

16. **Access for P~~p~~ersons with D~~d~~isabilities.** The Alliance ensures access for p~~P~~ersons with

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disabilities in compliance with the requirements of Titles II and III of the Americans with Disabilities Act of 1990, section 1557 of the Affordable Care Act of 2010, sections 504 and 508 of the Rehabilitation Act of 1973, Government Code sections 11135 and 7405.

16.1. Offering qualified interpreters when oral interpretation is a reasonable step to provide meaningful access.

16.2. Using qualified translators for written translation.

~~16.3.~~ Offering free, accurate, timely and confidential language services (Sections 3-5)

16.3.

16.4. Ensuring access for individuals with disabilities, including accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces and accessible drinking water. Accessibility is monitored through the Alliance's physical accessibility review surveys. See Policy and Procedure *QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Survey (PARS)* for details.

16.5. Providing auxiliary aids and services to individuals with disabilities.

16.6. Making reasonable changes to policies, practices, and procedures to provide equal access for members with disabilities. Policies and procedures are reviewed annually by all internal departments to ensure there are no barriers for members to access care.

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DEFINITIONS / ACRONYMS

ACA: Affordable Care Act
ASL~~LS~~: American Sign Language
CLS: Cultural and Linguistic Services
Alternative~~e~~ Format: Formats such as Braille, audio format, large print ~~text~~ (no less than 20 point Arial font ~~or larger~~), and ~~audio or other electronic formats~~ accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate ~~that support access to information for persons with disabilities.~~
Auxiliary Aids: Devices used by persons with disabilities for communication, such as Telephone Typewriters (TTY) or Telecommunication Devices for the Deaf (TDD).
OCR: Office of Civil Rights
FFS: Fee for Service

CRS – California Relay Services
Cued language transliterators - Individuals who represent or spell by using a small number of handshapes.
Interpretation services include: (1) availability of trained bilingual plan and provider staff (2) hiring staff interpreters (3) contracting with an outside interpreter service for qualified interpreters (4) arranging for the services of voluntary, qualified community interpreters (5) contracting for telephone, videoconferencing, or other telecommunication supported interpretation services.
Interpreter - An interpreter is a person who renders a message spoken in one language into one or more languages.
LEP – Limited English Proficient
Oral transliterators – Individuals who represent or spell in characters of another alphabet.
TDD – Telecommunications Devices for Deaf
Translation – Translation is the replacement of written text from one language into another.
TTY – (Teletypewriter) is a communication device used by people who are deaf, hard-of-hearing, or have severe speech impairment.

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AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Provider Network

COMPLIANCE COMMITTEE REVISION HISTORY

7/1/1998, 11/1/04, 1/1/08, 9/29/09, 2/26/10, 3/13/12, 4/13/2015, 3/24/2016, 11/10/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, TBD

RELATED POLICIES AND PROCEDURES

CLS-008	Member Assessment of Cultural and Linguistic Needs
CLS-009	CLS Program - Contracted Providers
CLS-010	CLS Program - Staff Training
CLS-011	Compliance Monitoring of C & L Program
C&O-001	Community Relations and Outreach Activities
QI-105	Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical

Accessibility Review Survey (PARS)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

Americans with Disabilities Act of 1990
CFR, Part 42 Sections 438.10(d), 439.10, 438.404 and 438.408
DHCS All Plan Letter 21-004
DHCS All Plan Letter 22-002
DHCS Exhibit A, contract Attachments 9, Sections 13 and 14
Government Code Sections 11135 and 7405
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Title 28, CCR sections 1300.67.04(c)(2)(A)-(B) and 1300.67.04 (c) (2)(G)(v) – (c) (4)
Rehabilitation Act of 1973, Sections 504 and 508
-SB 223 Health Care Language Assistance Services
-SB 1423 Oral Interpretation Services
W&I Code 14029.91

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MONITORING

This policy will be reviewed annually to ensure effectiveness.

POLICY AND PROCEDURE

Policy Number	CLS-008
Policy Name	Member Assessment of Cultural and Linguistic Needs
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Manager, Health Education
Line(s) of Business	Medi-Cal and Group Care
Effective Date	4/13/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health complies with all contractual and regulatory requirements pertaining to the assessment of enrollees to offer its members culturally and linguistically appropriate services. Results of the assessments are used to determine threshold languages and translation of member informing materials for members. The Alliance's cultural and linguistic assessments comply with Title 22, CCR, Section 53858(e)(6); Title 28, CCR, Section 1300.68(b)(3); and the Department of Health Care Services (DHCS) APL 17-006.

PROCEDURE

1. The Alliance collects reported ethnicity and preferred language information from the Department of Health Care Services (DHCS) (Medi-Cal) and employer eligibility files (Group Care). In addition, Alliance staff documents reported member ethnicity, preferred language, use of interpreters and member requested changes to ethnicity or preferred language in the Alliance information systems. Quarterly reports are reviewed by Alliance staff at the Cultural and Linguistic Services Subcommittee meetings.

2. The Alliance assesses members' language needs and demographic profile for Medi-Cal and Group Care lines of business at least annually. At minimum the following information is provided as part of this member assessment:
   2.1. Total members by race/ethnicity, preferred language, age, sex and SPD aid code
   2.2. Total members as percent of membership
   2.3. Comparison of prior year(s) to current year by percent change.

3. The Alliance implements the Population Needs Assessment (PNA) of Medi-Cal and Group Care members annually (See *PH-005 Population Needs Assessment* for details on purpose, content, implementation, and reporting requirements of the Population Needs Assessment).

4. The Alliance translates, using a qualified translator, member informing materials into languages that meet the following criteria:
   4.1. A population group of eligible beneficiaries residing in the Alliance's service area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000 or five-percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and
   4.2. A population group of eligible beneficiaries residing in the Alliance's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes (Concentration Standard Language).
   4.3. All Alliance departments communicating with members are responsible for ensuring their staff translate or interpret all member informing materials. The Alliance's Communications and Outreach Department has the responsibility of providing translations using qualified translators of those materials as needed. See *CLS-003 Language Assistance Services* and *C&O-001 Community Relations and Outreach Activitie*s for policies and procedures regarding document translation.

5. Alliance Cultural and Linguistic Services and Communications and Outreach work together to ensure that members receive regular notices with regards to availability of free Language Assistance Services (LAS) for members. Messages include the following content:
   5.1. Information on availability of LAS in all threshold languages for each line of business.
   5.2. Information on how to request LAS
   5.3. No-cost nature of LAS
   5.4. Encouragement of members to use professional interpreters and not use family, friends, or non-qualified interpreters
   5.5. Not to use children as interpreters except in an emergency

6. The Alliance informs LEP members of language services at no cost through the following strategies (For more details on these notices and strategies for informing members about language services, see *CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities.*):
   6.1. Member ID card letter
   6.2. Alliance provider and member websites
   6.3. Plan member newsletter
   6.4. Plan letters connecting members to plan services including Health Education and Case Management
   6.5. Notice of non-discrimination, language assistance and effective communication for individuals with disabilities and taglines offering free language assistance services

7. The Alliance maintains a list of non-English languages likely to be encountered among the Plan's members. This information is also documented in the enrollee assessments. Member demographics are also a part of the plan's annual Diversity Equity and Inclusion (DEI) Training . All employees are required to complete a yearly DEI Training, and the training

is made available to plan's provider network on the plan's website. See Alliance policy *HR-027 DEI Training Program* for more details.

DEFINITIONS / ACRONYMS

DHCS: Department of Healthcare Services
LAS: Language Assistance Services
LEP: Limited English Proficiency
Member Informing Materials: Informing materials/documents provide essential information to members regarding access to and usage of plan services. Examples include member handbooks, newsletters, provider directory, notices of action and form letters.
PNA: Population Needs Assessment. The PNA is an assessment of the demographics, health status, health care access and health disparities of the Alliance member population.
DEI: Diversity, Equity, and Inclusion

AFFECTED DEPARTMENTS/PARTIES

Case Management
Communications and Outreach
Health Care Analytics
Health Care Services
Operations

REVISION HISTORY

Replaced MED-CLS-006 Language Identification 11/20/08, 4/13/2015, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, TBD

RELATED POLICIES AND PROCEDURES

HED-003 Population Needs Assessment (GNA)
CLS-001 Cultural and Linguistic Program Description
CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-009 Cultural and Linguistic Services Program - Contracted Providers
CLS-010 Cultural and Linguistic Services Program_ Staff Training
CLS-011 Compliance Monitoring of Cultural and Linguistic Services Program
C&O-001 Community Relations and Outreach Activities
HR-027 DEI Training Program

REFERENCES

Title 22, CCR, Section 53858(e)(6)
Title 28, CCR, Section 1300.68(b)(3)
Health and Safety Code section 1367.04(b)
DHCS Contract Exhibit A, Attachment 9
DHCS All Plan Letter 17-011 Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act
DHCS All Plan Letter 19-011 Population Needs Assessment (PNA)
DHCS All Plan Letter 23-025

MONITORING

This policy will be reviewed annually to ensure effectiveness and it meets regulatory and contractual standards. Monitoring activities are described in the Alliance Policy *CLS-011 Compliance Monitoring of Cultural and Linguistic Services*.

POLICY AND PROCEDURE

Policy Number	CLS-008
Policy Name	Member Assessment of Cultural and Linguistic Needs
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Manager, Health Education
Line(s) of Business	Medi-Cal and Group Care
Effective Date	4/13/2015
Subcommittee Name	~~Health Care Quality~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	TBD~~3/21/2023~~

POLICY STATEMENT

Alameda Alliance for Health complies with all contractual and regulatory requirements pertaining to the assessment of enrollees to offer its members culturally and linguistically appropriate services. Results of the assessments are used to determine threshold languages and translation of member informing materials for members. The Alliance's cultural and linguistic assessments comply with Title 22, CCR, Section 53858(e)(6); Title 28, CCR, Section 1300.68(b)(3); and the Department of Health Care Services (DHCS) APL 17-006.

PROCEDURE

1. The Alliance collects reported ethnicity and preferred language information from the Department of Health Care Services (DHCS) (Medi-Cal) and employer eligibility files (Group Care). In addition, Alliance staff documents reported member ethnicity, preferred language, use of interpreters and member requested changes to ethnicity or preferred language in the Alliance information systems. Quarterly reports are reviewed by Alliance staff at the Cultural and Linguistic Services Subcommittee meetings.

2. The Alliance assesses members' language needs and demographic profile for Medi-Cal and Group Care lines of business at least annually. At minimum the following information is provided as part of this member assessment:
   2.1. Total members by race/ethnicity, preferred language, age, sex and SPD aid code
   2.2. Total members as percent of membership

2.3. Comparison of prior year(s) to current year by percent change.

3. The Alliance implements the Population Needs Assessment (PNA) of Medi-Cal and Group Care members annually (See *PH-005 Population Needs Assessment* ~~*HED-003 Population Needs Assessment*~~ for details on purpose, content, implementation, and reporting requirements of the Population Needs Assessment).

4. The Alliance translates, using a qualified translator, member informing materials into languages that meet the following criteria:
   4.1. A population group of eligible beneficiaries residing in the Alliance's service area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000 or five-percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and
   4.2. A population group of eligible beneficiaries residing in the Alliance's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes (Concentration Standard Language).
   4.3. All Alliance departments communicating with members are responsible for ensuring their staff translate or interpret all member informing materials. The Alliance's Communications and Outreach Department has the responsibility of providing translations using qualified translators of those materials as needed. See *CLS-003 Language Assistance Services* and *C&O-001 Community Relations and Outreach Activities* for policies and procedures regarding document translation.

5. Alliance Cultural and Linguistic Services and Communications and Outreach work together to ensure that members receive regular notices with regards to availability of free Language Assistance Services (LAS) for members. Messages include the following content:
   5.1. Information on availability of LAS in all threshold languages for each line of business.
   5.2. Information on how to request LAS
   5.3. No-cost nature of LAS
   5.4. Encouragement of members to use professional interpreters and not use family, friends, or non-qualified interpreters
   5.5. Not to use children as interpreters except in an emergency

6. The Alliance informs LEP members of ~~free~~ language services at no cost through the following strategies (For more details on these notices and strategies for informing members about language services, see *CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities.* ~~*Language Assistance Services.*~~):
   6.1. Member ID card letter
   6.2. ~~Member and provider pages of the~~ Alliance provider and member websites
   6.3. Plan member newsletter
   6.4. Plan letters connecting members to plan services including Health Education and Case Management
   6.5. Notice of non-discrimination, language assistance and effective communication for individuals with disabilities and taglines offering free language assistance services

7. The Alliance maintains a list of non-English languages likely to be encountered among the Plan's members. This information is also documented in the enrollee assessments. Member demographics are also a part of the plan's annual ~~Cultural Sensitivity Trainin~~Diversity Equity and Inclusion (DEI) Training~~g~~ ~~(CST)~~. All employees are required to complete a yearly ~~CST~~DEI Training, and the training is made available to plan's provider network on the plan's website. See Alliance policy *HR-027 DEI Training Program* for more details.

DEFINITIONS / ACRONYMS

DHCS: —Department of Healthcare Services

LAS: —Language Assistance Services

LEP: —Limited English Proficiency~~t~~

Member Informing Materials: —Informing materials/documents provide essential information to members regarding access to and usage of plan services. Examples include member handbooks, newsletters, provider directory, notices of action and form letters.

PNA: ~~–Group~~Population Needs Assessment. The PNA is an assessment of the demographics, health status, health care access and health disparities of the Alliance member population.
DEI: Diversity, Equity, and Inclusion

AFFECTED DEPARTMENTS/PARTIES

Case Management
Communications and Outreach
Health Care Analytics
Health Care Services
Operations

REVISION HISTORY

Replaced MED-CLS-006 Language Identification 11/20/08, 4/13/2015, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, TBD

RELATED POLICIES AND PROCEDURES

HED-003 Population Needs Assessment (GNA)
CLS-001 Cultural and Linguistic Program Description
CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-009 Cultural and Linguistic Services Program - Contracted Providers
CLS-010 Cultural and Linguistic Services Program_ Staff Training
CLS-011 Compliance Monitoring of Cultural and Linguistic Services Program
C&O-001 Community Relations and Outreach Activities
HR-027 DEI Training Program

REFERENCES

Title 22, CCR, Section 53858(e)(6)
Title 28, CCR, Section 1300.68(b)(3)
Health and Safety Code section 1367.04(b)
DHCS Contract Exhibit A, Attachment 9
DHCS All Plan Letter ~~(APL)~~ 17-011 Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act
DHCS All Plan Letter ~~(APL) APL~~ 19-011 Population Needs Assessment (PNA)
DHCS All Plan Letter 23-025

MONITORING

This policy will be reviewed annually to ensure effectiveness and it meets regulatory and contractual standards. Monitoring activities are described in the Alliance Policy *CLS-011 Compliance Monitoring of Cultural and Linguistic Services*.

POLICY AND PROCEDURE

Policy Number	CLS-009
Policy Name	Cultural and Linguistic Services (CLS) Program – Contracted Providers
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal and Group Care
Effective Date	2/13/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (Alliance) is committed to meeting the cultural and linguistic needs of our members. We contract with a diverse network of providers and ensure that our contracted health care providers, subcontractors, and downstream subcontractors are compliant with all standards related to the Alliance's Cultural and Linguistic Services Program.

All Alliance contracted providers, subcontractors, and downstream subcontractors must offer qualified interpretation services to Alliance Members at all points of contact for covered benefits. These standards are outlined in the following policies and procedures: *CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities, CLS-008 Enrollee Assessment of Cutural and Lingistic Needs, CLS-010 Staff Training*.

The Alliance's contracted provider network will deliver adequate acccess and availability of bilingual providers and office staff in its contracted network. The Alliance retains financial responsibility for these services unless delegated financial responsibility has been documented in a written contract.

The Alliance ensures that all delegated provider networks, subcontractors, and downstream subcontractors provide a Cultural and Linguisitc Services Program to Alliance Members and mechanisms are in place to fulfill their responsibilities, including administrative capacity, technical expertise, budgetary resources for language assistance and culturally responsive servcies. The Alliance reviews and identitifies problematic areas and effective action is take to improve care.

PROCEDURE

1. The Alliance engages with local providers of primary care, specialty, behavioral health, care management, and enhanced care management (ECM) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment and retainment of providers who can meet the cultural, language, age, and disability needs and preferences of our members.

2. Alliance contracts with healthcare providers and vendors, including subcontractors and downstream contractors, state the responsibility to comply with the Alliance Cultural and Linguistic Services program, which includes compliance with state and federal language and communication assistance requirements.

3. The Alliance ensures compliance of providers, subcontractors, and downstream contractors with the requirements for access to interpreter services for all limited English proficiency (LEP) Members by:
   - 3.1. Informing providers of the ways in which they can improve patient access to quality health care through culturally appropriate and linguistic services such as the Alliance's Interpreter Services:
     - 3.1.1. The Provider Manual, available on the Alliance provider website, describes provider responsibilities to provide culturally and linguistically appropriate services. The manual includes the Alliance Interpreter Services Guide that describes how to request interpreter services at no cost to providers or member.
     - 3.1.2. The Alliance distributes to providers a *Point to Your Language* sign as well for use in the office when interacting with LEP members to identify the need for interpretation and language requested.
     - 3.1.3. Providers are reminded about the Alliance interpreter services and the importance of professional interpreter services on the Alliance provider website, provider quarterly packets, provider visits, provider training curriculum and regularly distributed health education resource guides.
     - 3.1.4. Providers are required to participate in a Cultural Sensitivity Training when first contracted and yearly thereafter, which includes information on complying with the Alliance Cultural and Linguistic Services Program, assisting LEP members, accessing interpreter services and best practices for working with interpreters. See *CLS-010 Staff Cultural and Linguistic Training* for details.

3.2. Informing providers of the language needs of Alliance members:
   3.2.1. The Alliance includes the language needs of Alliance members assigned to clinics or provider offices on the member rosters.
   3.2.2. If providers need members' preferred language information, requests can be made through Provider Services or through the provider portal.
3.3. Monitoring provider performance through facility site reviews, the re-credentialing process, review/response to member grievances, and quarterly tracking of in-person and telephonic service requests:
   3.3.1. The Quality Improvement Department, through Facility Site Reviews, monitors provider performance for culturally appropriate and linguistic services (See *CLS-011 Compliance Monitoring of the Cultural and Linguistic Services Program*).
   3.3.2. The Cultural and Linguistic Services Subcommittee monitors grievances regarding provider language capacity and reviews in-person and telephonic service requests. Reports are forwarded to the Quality Improvement Health Equity Committee (QIHEC).
   3.3.3. Use of corrective action plans and retraining when indicated.

4. The Provider Services and Quality Improvement Departments collect information on the bilingual capacity of the provider network. All updates are entered into the Alliance provider database.
   4.1. During initial credentialing, provider language capacity is documented.
   4.2. Providers are asked to provide the Alliance quarterly updates to the languages available at their offices.
   4.3. The Quality Improvement Department monitors the adequacy of availability of bilingual providers through quarterly reports to the Cultural and Linguistic Subcommittee and forwarded to QIHEC for review. Provider Services and the Quality Improvement Departments work together to address any issues that arise.
   4.4. Providers are asked to maintain documentation of proficiency for all bilingual staff.

5. Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.
   5.1. All languages spoken at the office are listed below the provider listing, whether the provider is a Primary Care Provider or specialist.
   5.2. Member Services staff use this information to assist members in selecting an appropriate provider.

6. In the event that a Network provider, subcontractor or downstream subcontractor has religious or ethical objections to perform or otherwise support the provision of covered services, the Alliance will arrange for, coordinate, and ensure the member receives services in a timely manner through a provider with no moral objections.

6.1. Members are notified in the member handbook of the right to access services from another provider.
6.2. Members can call Member Services for assistance in identifying another provider. When appropriate, Member Services staff will refer the member to Case Management for care coordination support.

DEFINITIONS / ACRONYMS

ECM: Enhanced Care Management
Limited English Proficient (LEP): A person that is unable to speak, read, write, or understand the English language at a level that permits him/her to interact effectively with health and social services agencies and providers.

AFFECTED DEPARTMENTS/PARTIES

Alliance Provider Network
Member Services
Provider Services
Quality Improvement
Vendor Management

REVISION HISTORY

2/13/2015, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, TBD

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Program Description
CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-008 Enrollee Assessment of Cutural and Lingistic Needs
CLS-010 Cultural and Linguistic Services Program - Staff Training
CLS-011-Compliance Monitoring of Cultural and Linguistic Services Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

CA Health and Safety Code section 1367.04(f)
Title 28, CCR 1300.67.04

MONITORING

This policy will be reviewed annually to ensure effectiveness and meets regulatory and contractual standards. Monitoring activities of the Cultural and Linguistic Services Program are described in the Alliance Policy *CLS-011 Compliance Monitoring of Cultural and Linguistic Services*.

POLICY AND PROCEDURE

Policy Number	CLS-009
Policy Name	Cultural and Linguistic Services (CLS) Program – Contracted Providers
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal and Group Care
Effective Date	2/13/2015
Subcommittee Name	~~Health Care Quality~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	~~3/21/2023~~TBD

POLICY STATEMENT

Alameda Alliance for Health (~~"~~Alliance~~"~~) is committed to meeting the cultural and linguistic needs of our members. We contract with a diverse network of providers and ensure that our contracted health care providers, subcontractors, and downstream subcontractors are compliant with all standards related to the Alliance's Cultural and Linguistic Services Program.

All Alliance contracted providers, subcontractors, and downstream subcontractors must offer qualified interpretation services to Alliance Members at all points of contact for covered benefits. These standards are outlined in the following policies and procedures: *CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities, CLS-008 Enrollee Assessment of Cutural and Lingistic Needs, CLS-010 Staff Training*.

The Alliance's contracted provider network will deliver adequate acccess and availability of bilingual providers and office staff in its contracted network. The Alliance retains financial

responsibility for these services unless delegated financial responsibility has been documented in a written contract.

The Alliance ensures that all delegated provider networks, subcontractors, and downstream subcontractors provide a Cultural and Linguisitc Services Program to Alliance Members and mechanisms are in place to fulfill their responsibilities, including administrative capacity, technical expertise, budgetary resources for language assistance and culturally responsive servcies. The Alliance reviews and identitifies problematic areas and effective action is take to improve care.

PROCEDURE

1. The Alliance engages with local providers of primary care, specialty, behavioral health, care management, and enhanced care management (ECM) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment and retainment of providers who can meet the cultural, language, age, and disability needs and preferences of our members.

2. Alliance contracts with healthcare providers and vendors, including subcontractors and downstream contractors, state the responsibility to comply with the Alliance Cultural and Linguistic Services program, which includes compliance with state and federal language and communication assistance requirements.

3. The Alliance ensures compliance of providers, subcontractors, and downstream contractors with the requirements for access to interpreter services for all ~~L~~limited English p~~P~~roficiency~~t~~ (LEP) Members by:
   3.1. Informing providers of the ways in which they can improve patient access to quality health care through culturally appropriate and linguistic services such as the Alliance's Interpreter Services:
      3.1.1. The Provider Manual, available on the Alliance provider website, describes provider responsibilities to provide culturally and linguistically appropriate services. The m~~M~~anual includes the Alliance Interpreter Services G~~g~~uide that describes how to request interpreter services at no cost to providers or member.
      3.1.2. The Alliance distributes to providers a *Point to Your Language* sign as well for use in the office when interacting with LEP members to identify the need for interpretation and language requested.
      3.1.3. Providers are reminded about the Alliance interpreter services and the importance of professional interpreter services on the ~~provider pages of the~~ Alliance provider website, provider quarterly packets, ~~announcements in regular~~ provider visits, provider training curriculum and regularly distributed health education resource guides.

3.1.4. Providers are required to participate in a Cultural Sensitivity Training when first contracted and yearly thereafter, which includes information on complying with the Alliance Cultural and Linguistic Services Program, assisting LEP members, accessing interpreter services and best practices for working with interpreters. See *CLS-010 Staff Cultural and Linguistic Training* for details.

3.2. Informing pProviders of the language needs of Alliance members:

3.2.1. The Alliance includes the language needs of Alliance members assigned to clinics or provider offices on the member rosters.

3.2.2. If providers need members' preferred language information, requests can be made through Provider Services or through the provider website portal.

3.3. Monitoring provider performance through facility site reviews, the re-credentialing process, review/response to member grievances, and quarterly tracking of in-person and telephonic service requests:

3.3.1. The Quality Improvement Department, through Facility Site Reviews, monitors provider performance for culturally appropriate and linguistic services (See *CLS-011 Compliance Monitoring of the Cultural and Linguistic Services Program*).

3.3.2. The Cultural and Linguistic Services Subcommittee monitors grievances regarding provider language capacity and reviews in-person and telephonic service requests. Reports are forwarded to the Health Care QualityQuality Improvement Health Equity Committee (QIHEC).

3.3.3. Use of corrective action plans and retraining when indicated.

4. The Provider Services and Quality Improvement Departments collect information on the bilingual capacity of the provider network. All updates are entered into the Alliance provider database.

4.1. During initial credentialing, provider language capacity is documented.

4.2. Providers are asked to provide the Alliance quarterly updates to the languages available at their offices.

4.3. The Quality Improvement Department monitors the adequacy of availability of bilingual providers through quarterly reports to the Cultural and Linguistic Subcommittee and forwarded to the Health Care Quality CommitteeQIHEC for review. Provider Services and the Quality Improvement Departments work together to address any issues that arise.

4.4. Providers are asked to maintain documentation of proficiency for all bilingual staff.

5. Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

5.1. All languages spoken at the office are listed below the provider listing, whether the provider is a Primary Care Physician Provider or specialist.

5.2. Member Services staff use this information to assist members in selecting an appropriate provider.

6. In the event that a Network provider, subcontractor or downstream subcontractor has religious or ethical objections to perform or otherwise support the provision of covered services, the Alliance will arrange for, coordinate, and ensure the member receives services in a timely manner through a provider with no moral objections.
   6.1. Members are notified in the member handbook of the right to access services from another provider.
   6.2. Members can call Member Services for assistance in identifying another provider. When appropriate, Member Services staff will refer the member to Case Management for care coordination support.

DEFINITIONS / ACRONYMS

ECM: —Enhanced Care Management

Limited English Proficient (LEP): A person that is unable to speak, read, write, or understand the English language at a level that permits him/her to interact effectively with health and social services agencies and providers.

AFFECTED DEPARTMENTS/PARTIES

Alliance Provider Network
Member Services
Provider Services
Quality Improvement
Vendor Management

REVISION HISTORY

2/13/2015, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, TBD

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Program Description
CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities

CLS-008 Enrollee Assessment of Cutural and Lingistic Needs
CLS-010 Cultural and Linguistic Services Program - Staff Training
CLS-011-Compliance Monitoring of Cultural and Linguistic Services Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

CA Health and Safety Code section 1367.04(f)
Title 28, CCR 1300.67.04

MONITORING

This policy will be reviewed annually to ensure effectiveness and meets regulatory and contractual standards. Monitoring activities of the Cultural and Linguistic Services Program are described in the Alliance Policy *CLS-011 Compliance Monitoring of Cultural and Linguistic Services*.

POLICY AND PROCEDURE

Policy Number	CLS-010
Policy Name	Cultural and Linguistic Services Program: Staff Training and Assessment
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal and Group Care
Effective Date	2/13/2015
Subcommittee Name	~~Health Care~~ Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	TBD~~3/21/2023~~

POLICY STATEMENT

Alameda Alliance for Health (~~"~~Alliance~~"~~) ensures that all staff, network providers, and subcontractors are compliant with the Cultural and Linguistic Services Program through ~~cultural sensitivity training~~cultural competency/humility, sensitivity, health equity and diversity training ~~that is provided on an annual basis.~~ . The purpose of the training is to promote access and delivery of services in a culturally competent manner to all members and potential members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56.~~See Alliance policy *HR-027: DEI Training Program* for more details.~~

Additionally, b~~B~~ilingual staff that is hired to work with Alliance's l~~L~~imited English p~~P~~roficiency~~t~~ (LEP) members receive bilingual proficiency assessments. Bilingual members' proficiency is regularly monitored and any areas of concern addressed.

PROCEDURE

1. The ~~Health Education department~~~~Population Health and Equity Unit~~ Alliance creates and updates on an annual basis a Cultural Sensitivity Training that includes the following:

1.1. Knowledge of the Alliance's policies and procedures related to language assistance.
1.2. Instruction on working effectively with members and interpreters through all means of communication.
1.3. Understanding the cultural diversity of the Alliance's member population and sensitivity to cultural difference relevant to delivery of health care interpretation services.
~~1.3.~~1.4. How structural and institutional racism and health inequities impact members, staff, network providers, subcontractors, and downstream subcontractors.
~~1.4.~~1.5. Information about the identified cultural groups in its service area including but not limited to members with:
~~1.4.1.~~1.5.1. Limited English proficiency
~~1.4.2.~~1.5.2. Refugee and immigrant status
~~1.4.3.~~1.5.3. Diverse cultural and ethnic backgrounds
~~1.4.4.~~1.5.4. Seniors and persons with disabilities
1.5.5. Gender, gender identity and sexual orientation

~~1.5.~~1.6. ~~Cultural competency~~Information about the health inequities and identified cultural groups in Alameda County including, but not limited to the groups' ~~as it relates to member's~~ beliefs about illness and health; need for gender affirming care; ~~,~~ methods of interacting with providers and the health care structure; ~~,~~traditional home remedies that can impact treatment;~~,~~ and health literacy needs.

~~The Compliance Department, in coordination with the Health Education Department~~Population Health and Quity Unit~~, provides Cultural and Linguistic training for Alliance staff.~~ All Alliance staff are required to participate in the Cultural Sensitivity Training within the first 90-days of employment and annually thereafter. See Alliance policy *HR-027: DEI Training Program* for more details on implementation. ~~All departments offering members direct services participate in, at minimum, a yearly training covering the topics specified under Item A. Departments include at minimum:~~
2.

3. The Alliance ensures network providers and allied health personnel receive pertinent information regarding the Alliance Population Needs Assessment (PNA) findings using a communication method to ensure the information can be accessed and understood. See Alliance policy *PH-005 Population Needs Assessment* for details.
~~Member Services~~
~~Communications and Outreach~~
~~Case and Disease Management~~
~~Health Education~~
~~Grievance & Appeals~~
~~Quality Improvement~~

4. The Alliance's network providers, subcontractors, and downstream subcontractors ~~directly contracted and delegated providers~~ must also ~~complete a~~provider cultural

competency/humility, sensitivity, health equity and diversity training to staff at key points of contact with members.

4.1. ~~sensitivity training.~~ Providers are informed of the training requirements through new provider orientations, provider quarterly packets, ~~the~~ provider manual and provider office visits. They have access to the Alliance Cultural Sensitivity Training on the ~~provider pages of the~~ Alliance provider website.

~~1.6.~~4.2. Additional training and resources on providing cultural and linguistic services are posted on the Alliance provider website and promoted through regular provider visits.

~~2.~~5. The Human Resources Department requires that bilingual or multilingual employees are assessed on their ~~bilingual~~ linguistic proficiency prior to performing duties that use ~~bilingual~~ multilingual skills. See Alliance p~~P~~olicy *HR-020 Assessing Bilingual Skills* for more details.

~~2.1.~~5.1. An employee linguistic~~bilingual~~ proficiency assessment includes assessing:

~~2.1.1.~~5.1.1. Proficiency in English and the relevant interpreted language

~~2.1.2.~~5.1.2. Knowledge of healthcare terminology and concepts relevant to health care delivery systems in both languages

~~2.1.3.~~5.1.3. Understanding of the ethical principles, protocols and guidance on roles and intervention as promulgated by the California Healthcare Interpreters Association (CHIA)

~~2.2.~~5.2. Designated ~~bilingual~~ multilingual staff are assessed.

~~2.3.~~5.3. The test is performed by a qualified outside vendor or staff member who has successfully completed a ~~bilingual~~ linguistic assessment.

~~2.4.~~5.4. A~~The a~~ssessment ~~is~~s are pass/fail. Staff who fail their departmental test for a certain non-English language will not be permitted to serve members in that language until they pass the assessment.

~~2.5.~~5.5. Human Resources will maintain a list of current ~~bilingual~~ multilingual employees including the language(s), testing date and clinical or non-clinical capacity.

~~2.6.~~5.6. Human Resources or their designee, reviews the quality of multi~~bi~~lingual staff communication with members through yearly reassessment.

~~2.7.~~5.7. Member Services reviews cultural and linguistic skills in their monthly quality monitoring of member services calls.

~~2.8.~~5.8. Supervisors provide feedback to the employee about their performance including areas for improvement. Retraining or reassessment takes place as deemed necessary.

DEFINITIONS / ACRONYMS

LEP: Limited English Proficiency - A person that is unable to speak, read, write or understand the English language at a level that permits him/her to interact effectively with health and social services agencies and providers.

CHIA: California Healthcare Interpreters Association

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Provider Network

REVISION HISTORY

2/13/2015, 3/24/2016, 11/10/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/17/2022, 3/21/2023, TBD

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Program Description
CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-009 Cultural and Linguistic Services Program - Contracted Providers
CLS-011 Monitoring of Cultural and Linguistic Services
HR-020 Assessing Bilingual Skills
HR-027-DEI Training Program
PH-005 Population Needs Assessment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

DHCS Contract Exhibit A, Attachment 9, Section 13
Title 28 §1300.67.04(c)(2) Language Assistance Program
U.S. Code of Federal Regulations, Title 42, CFR Section 440.262
DHCS All Plan Letter 23-025

MONITORING

This policy will be reviewed annually to ensure effectiveness and meets regulatory and contractual standards. Monitoring activities of the Cultural and Linguistic Services Program are described in the Alliance Policy *CLS-011 Monitoring of Cultural and Linguistic Services*.

POLICY AND PROCEDURE

Policy Number	CLS-010
Policy Name	Cultural and Linguistic Services Program: Staff Training and Assessment
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal and Group Care
Effective Date	2/13/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (Alliance) ensures that all staff, network providers, and subcontractors are compliant with the Cultural and Linguistic Services Program through cultural competency/humility, sensitivity, health equity and diversity training. The purpose of the training is to promote access and delivery of services in a culturally competent manner to all members and potential members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56.

Additionally, bilingual staff that is hired to work with Alliance's limited English proficiency (LEP) members receive bilingual proficiency assessments. Bilingual members' proficiency is regularly monitored and any areas of concern addressed.

PROCEDURE

1. The Alliance creates and updates on an annual basis a Cultural Sensitivity Training that includes the following:
   1.1. Knowledge of the Alliance's policies and procedures related to language assistance.

1.2. Instruction on working effectively with members and interpreters through all means of communication.
1.3. Understanding the cultural diversity of the Alliance's member population and sensitivity to cultural difference relevant to delivery of health care interpretation services.
1.4. How structural and institutional racism and health inequities impact members, staff, network providers, subcontractors, and downstream subcontractors.
1.5. Information about the identified cultural groups in its service area including but not limited to members with:
1.5.1. Limited English proficiency
1.5.2. Refugee and immigrant status
1.5.3. Diverse cultural and ethnic backgrounds
1.5.4. Seniors and persons with disabilities
1.5.5. Gender, gender identity and sexual orientation

1.6. Information about the health inequities and identified cultural groups in Alameda County including, but not limited to the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with providers and the health care structure; traditional home remedies that can impact treatment; and health literacy needs.

2. All Alliance staff are required to participate in the Cultural Sensitivity Training within the first 90-days of employment and annually thereafter. See Alliance policy *HR-027: DEI Training Program* for more details on implementation.

3. The Alliance ensures network providers and allied health personnel receive pertinent information regarding the Alliance Population Needs Assessment (PNA) findings using a communication method to ensure the information can be accessed and understood. See Alliance policy *PH-005 Population Needs Assessment* for details.

4. The Alliance's network providers, subcontractors, and downstream subcontractors must also provider cultural competency/humility, sensitivity, health equity and diversity training to staff at key points of contact with members.
4.1. Providers are informed of the training requirements through new provider orientations, provider quarterly packets, provider manual and provider office visits. They have access to the Alliance Cultural Sensitivity Training on the Alliance provider website.
4.2. Additional training and resources on providing cultural and linguistic services are posted on the Alliance provider website and promoted through regular provider visits.

5. The Human Resources Department requires that bilingual or multilingual employees are assessed on their linguistic proficiency prior to performing duties that use multilingual skills. See Alliance policy *HR-020 Assessing Bilingual Skills* for more details.
5.1. An employee linguistic proficiency assessment includes assessing:
5.1.1. Proficiency in English and the relevant interpreted language

5.1.2. Knowledge of healthcare terminology and concepts relevant to health care delivery systems in both languages
5.1.3. Understanding of the ethical principles, protocols and guidance on roles and intervention as promulgated by the California Healthcare Interpreters Association (CHIA)

5.2. Designated multilingual staff are assessed.
5.3. The test is performed by a qualified outside vendor or staff member who has successfully completed a linguistic assessment.
5.4. Assessments are pass/fail. Staff who fail their departmental test for a certain non-English language will not be permitted to serve members in that language until they pass the assessment.
5.5. Human Resources will maintain a list of current multilingual employees including the language(s), testing date and clinical or non-clinical capacity.
5.6. Human Resources or their designee, reviews the quality of multilingual staff communication with members through yearly reassessment.
5.7. Member Services reviews cultural and linguistic skills in their monthly quality monitoring of member services calls.
5.8. Supervisors provide feedback to the employee about their performance including areas for improvement. Retraining or reassessment takes place as deemed necessary.

DEFINITIONS / ACRONYMS

LEP: Limited English Proficiency **-** A person that is unable to speak, read, write or understand the English language at a level that permits him/her to interact effectively with health and social services agencies and providers.
CHIA: California Healthcare Interpreters Association

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Provider Network

REVISION HISTORY

2/13/2015, 3/24/2016, 11/10/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/17/2022, 3/21/2023, TBD

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Program Description
CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-009 Cultural and Linguistic Services Program - Contracted Providers
CLS-011 Monitoring of Cultural and Linguistic Services

HR-020 Assessing Bilingual Skills
HR-027-DEI Training Program
PH-005 Population Needs Assessment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

DHCS Contract Exhibit A, Attachment 9, Section 13
Title 28 §1300.67.04(c)(2) Language Assistance Program
U.S. Code of Federal Regulations, Title 42, CFR Section 440.262
DHCS All Plan Letter 23-025

MONITORING

This policy will be reviewed annually to ensure effectiveness and meets regulatory and contractual standards. Monitoring activities of the Cultural and Linguistic Services Program are described in the Alliance Policy *CLS-011 Monitoring of Cultural and Linguistic Services*.

POLICY AND PROCEDURE

Policy Number	CLS-011
Policy Name	Compliance Monitoring of Cultural and Linguistic Services Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal and Group Care
Effective Date	2/13/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") monitors, improves, and evaluates the established Cultural and Linguistic Services (CLS) Program as a part of the Alliance's Quality Improvement Program. As part of the examination, all processes related to providing cultural and linguistic services are monitored including:

A. Quality Improvement Program Work Plan activities related to language assistance programs.
B. Reports on Alliance provision of language services to members, including interpretation, translation, and request for alternative formats.
C. Member and provider grievances and complaints and potential quality issues (PQI) related to cultural and linguistic services.
D. Information with regards to the Alliance's member language needs and demographic profile.
E. The Alliance's staff bilingual qualifications, training requirements and training materials
F. Network providers' compliance to requirements and ability to meet the cultural and linguistic needs of members.

The Alliance's Quality Improvement (QI) Department is responsible for monitoring the Cultural and Linguistic Services Program and evaluating its effectiveness. The Alliance's Quality Improvement Program and Language Assistance Program work plan updates are reported to the

Quality Improvement Health Equity Committee (QIHEC) for recommendations. Additionally, the Alliance's Compliance Department oversees external cultural and linguistic services delegated to entities through annual auditing activities to ensure compliance is met with regulatory and contractual standards. If deficiencies are cited, the Alliance will issue a corrective action plan (CAP) to the delegate entity to ensure those deficiencies are fully resolved prior to closing out the audit.

The QI Department monitors the language assistance services of its directly contracted provider network to ensure they 1) meet the cultural and linguistic needs of Alliance members and 2) that Alliance providers continuously abide by the standards set forth in the Alliance's Department of Health Care Services (DHCS) contract and all state and federal regulatory requirements. The Alliance takes immediate action when deficiencies are identified, and when necessary, CAPs are created for providers and monitored to ensure ongoing problematic issues are addressed.

PROCEDURE

1. Language Assistance Services Monitoring

1.1. Through facility site reviews, the following are reviewed, and CAPs are put into place per *QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs) and Physical Accessibility Review Surveys (PARS)* as needed:

1.1.1. Twenty-four/seven (24/7) access to telephonic interpreter services for limited English proficiency (LEP) members.

1.1.2. Interpreter services are made available in identified Alliance threshold languages.

1.1.3. Persons providing language interpreter services on site demonstrate training in medical interpretation, including conversational fluency, medical terminology for medical staff and non-medical staff. This must be documented.

1.1.4. The Medical Record Review (MRR) checks if the primary language and linguistic services needs of non- or LEP or deaf or hard of hearing persons as well as any refusal to use professional interpreter services are prominently noted.

1.1.5. Documentation of site personnel receiving information and/or training on cultural and linguistic appropriate services.

1.1.6. Verified evidence of staff training or written cultural and linguistic information on site and explanation of how to use the information.

1.1.7. Confirmation that site personnel have received information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act. Training content should include information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings.

1.2. The QI Department reviews monthly reports of language services provided to members. The report includes services provided by language, as well as the number of unfilled requests. The Cultural and Linguistic Services Subcommittee (CLSS) and the Quality Improvement Health Equity Committee (QIHEC) review a quarterly language services trending report and make recommendations when there is non-compliance. Provider or

vendor education and/or CAPs may be put into place to address non-compliance and monitored by the CLSS.

1.3. Member experience surveys include questions regarding the experience of limited English proficient members in obtaining interpreter services. Surveys solicit feedback from members regarding coordination of appointments with an interpreter, availability of interpreters who speak the enrollee's preferred language and the quality of interpreter services received.
  1.3.1. The Alliance conducts ongoing CG-CAHPS surveys post primary care appointments and annual CAHPS surveys. See Alliance policy *QI-117 Member Satisfaction Survey.*
    1.3.1.1. The CG-CAHPS and CAHPS surveys are translated into the Alliance threshold languages and sent in the member's preferred language.
  1.3.2. The Alliance also conducts an annual timely access survey focused on language assistance services designed to satisfy § 1300.67.2.2 California Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements. The survey will:
    1.3.2.1. Obtain enrollees' perspectives and concerns regarding their experience obtaining timely appointments for health care services.
    1.3.2.2. Inform enrollees of their right to obtain an appointment within each of the time-elapsed standards, and their right to receive interpreter services at that appointment.
    1.3.2.3. Evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining the enrollee's perspectives and concerns regarding:
      1.3.2.3.1. Coordination of appointments with an interpreter;
      1.3.2.3.2. Availability of interpreters who speak the enrollee's preferred language; and
      1.3.2.3.3. Quality of interpreter services received.
    1.3.2.4. Be translated into the enrollee's preferred language, in those situations where the plan is aware of the enrollee's preferred language; and the enrollee's preferred language is one of the top 15 languages spoken by limited English proficient individuals in California as determined by the DHCS.
  1.3.3. All surveys are sent with the Non-Discrimination Notice and Taglines members are invited to communicate with the Alliance to complete the survey by telephone in their preferred language. The taglines are written in the top 15 languages spoken by limited English proficient individuals as determined by DHCS.

1.4. The Alliance provider satisfaction survey includes questions to receive provider perspectives and concerns with the Alliance language assistance program. Questions include soliciting feedback regarding coordination of appointments with an interpreter, the availability of interpreters based on the needs of an enrollee and the ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.
  1.4.1. The Alliance conducts a provider satisfaction survey annually.
  1.4.2. See Alliance policy *QI-118 Provider Satisfaction Survey* for details.

1.5. Grievance and Appeals addresses C&L grievances according to their timelines (See *G&A-003 Grievance Receipt, Review and Resolution*) and creates a quarterly report of

member grievances and appeals related to cultural and linguistic access to services and quality of services. The CLSS and the QIHEC review a quarterly C&L related grievances trending report and make recommendations when there is non-compliance. When necessary, concerns are presented at Joint Operations Meetings (JOMs), providers receive reeducation and/or CAPs are created for providers or vendors and monitored to ensure problematic issues are addressed.

1.6. PQIs related to quality of language (QOL) may be reported by any member, staff, or provider as a part of our PQI process (See policy and procedure *QI-104 – Potential Quality of Care Issues (PQIs).* QOL PQIs are addressed to ensure quality concerns are investigated, member's interpreter services need and any re-education for providers is addressed. When necessary, CAPs are created for providers or vendors and monitored to ensure problematic issues are addressed.

1.7. Provider Services keeps an updated list of all contracted providers, which include their gender and their language and disability access capacity. Providers report any updates to language and access capacity at least quarterly. Changes are updated monthly in the Alliance data systems and made available to members, potential members, and the public in the Provider Directory online or in print upon request. The CLSS and QIHEC review a quarterly trending report on provider language capacity and make and monitor recommendations for network changes to meet the language needs of the Alliance membership.

2. Bilingual Staff and Vendor Language Capacity. The Alliance also monitors the linguistic capabilities of interpreters and bilingual staff.

2.1. All bilingual employees must complete an assessment prior to offering any interpretation services to members. The Alliance's Human Resources Department conducts the assessments. See *CLS-010 CLS Staff Training* for details. Each assessed employee must:

2.1.1. Demonstrate proficiency in both English and the other language(s) being assessed

2.1.2. Reveal a fundamental knowledge in health care terminology and concepts relevant to health care delivery systems in English and other language(s) being assessed Demonstrate training and education in interpreting ethics, conduct and confidentiality

The Alliance's Human Resources Department maintains a report listing all assessed bilingual employees, their linguistic capabilities, and their qualifications as clinical or non-clinical interpreters. The report is reviewed by the CLSS annually.

2.2. The QI Department monitors the contract with our languages service vendors and requests documentation on capacity and assessment of their interpreter staff.

2.2.1. A receipt/log of all requested interpretation services is kept demonstrating the availability of interpreter services to all members including the interpretative language being requested, date of service, and who provided the interpretation services.

2.2.2. The QI Department requests and reviews a yearly update of certifications of interpreters used through interpreter services vendors.

2.2.3. The Communications and Outreach Department keeps a log of all translated documents and attestation of translation accuracy.

3. Availability of Practitioners to meet the Cultural, Ethnic, Racial and Linguistic needs of members.

3.1. Annually, the Alliance assesses the cultural, ethnic, racial and linguistic needs of its members. Elements assessed include:
- 3.1.1. Member preferred language
- 3.1.2. Member Race/Ethnicity
- 3.1.3. Member Cultural Needs

3.2. Annually, the Alliance assesses the characteristics of network providers and determines if the member needs are met by the network. Elements assessed include:
- 3.2.1. Provider language capacity
- 3.2.2. Member survey results
- 3.2.3. Cultural and linguistic services grievances

3.3. Adjustments are made to the practitioner network to meet the cultural, ethnic, racial, and linguistic needs of members within defined geographical areas. Adjustments may include:
- 3.3.1. Requiring the completion of the cultural competency and sensitivity training
- 3.3.2. Making culturally and linguistically appropriate health education materials available to providers
- 3.3.3. Recruiting practitioners whose cultural and ethnic background are similar to the underrepresented member population.
- 3.3.4. The Alliance documents areas for improvement and recommendations in the annual "Availability of Practitioners to meet the Cultural Needs and Preferences and Preferences" report.

4. C&L Monitoring Reporting Structure

4.1. The QI Department receives all monitoring reports.

4.2. Reports are presented to the CLSS and forwarded to the QIHEC for input and approval.

4.3. A summary of the results is shared with the Community Advisory Committee (CAC) for input and suggested improvements.

4.4. The QI Department collaborates with internal Alliance departments and external providers to provide and implement new approaches or enhancements to existing services to ensure appropriate access and language assistance services and implements CAPs when necessary.

DEFINITIONS / ACRONYMS

CLS: Cultural and Linguistic Services
CAP" Corrective Action Plan
CAHPS: Consumer Assessment of Healthcare Providers & Systems
CG – CAHPS: Clinician and Group CAHPS survey
CLSS: Cultural and Linguistic Services Subcommittee – a subcommittee of the QIHEC
DHCS: Department for Health Care Services
QIHEC: Quality Improvement Health Equity Committee – a committee of the Alliance Board of Governors

JOM: Joint Operations Meetings
CAC: Community Advisory Committee
MRR: Medical Record Review
LEP: Limited English Proficiency
PQI: Potential Quality Issues: 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.
QI: Quality Improvement
QOL: Quality of Language

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

REVISION HISTORY

2/13/2015, 3/24/2016, 3/9/2017, 5/25/2017, 10/12/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, 12/19/2023, TBD

RELATED POLICIES AND PROCEDURES

CLS-008	Member Assessment of Cultural and Linguistic Needs
CLS-009	CLS Program - Contracted Providers
CLS-010	CLS Program - Staff Training
CLS-011	Compliance Monitoring of C & L Program
G&A-003	Grievance Receipt, Review and Resolution
QI-101	Quality Improvement Program
QI-104	Potential Quality of Care Issues
QI-105	Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-117	Member Satisfaction Survey
QI-118	Provider Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

Title 28, CCR 1300.67.04;1300.67.2.2
California Code, Health and Safety Code – HSC 1367.03
DHCS Contract, Exhibit A, Attachment 9, Section 14

MONITORING

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

POLICY AND PROCEDURE

Policy Number	CLS-011
Policy Name	Compliance Monitoring of Cultural and Linguistic Services Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal and Group Care
Effective Date	2/13/2015
Subcommittee Name	Quality Improvement ~~and~~ Health Equity Committee
Subcommittee Approval Date	~~11/17/2023~~TBD
Compliance Committee Approval Date	~~12/19/2023~~TBD

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") monitors, improves, and evaluates the established Cultural and Linguistic Services (CLS) Program as a part of the Alliance's Quality Improvement Program. As part of the examination, all processes related to providing cultural and linguistic services are monitored including:

A. Quality Improvement Program Work Plan activities related to language assistance programs.
B. Reports on Alliance provision of language services to members, including interpretation, translation, and request for alternative formats.
C. Member and provider grievances and complaints and potential quality issues (PQI) related to cultural and linguistic services.
D. Information with regards to the Alliance's member language needs and demographic profile.
E. The Alliance's staff bilingual qualifications, training requirements and training materials
F. Network providers' compliance to requirements and ability to meet the cultural and linguistic needs of members.

The Alliance's Quality Improvement (QI) Department is responsible for monitoring the Cultural and Linguistic Services Program and evaluating its effectiveness. The Alliance's Quality Improvement Program and Language Assistance Program work plan updates are reported to the

~~Health Care~~ Quality Improvement Health Equity Committee (QIHEC~~HCQC~~) for recommendations. Additionally, the Alliance's Compliance Department oversees external cultural and linguistic services delegated to entities through annual auditing activities to ensure compliance is met with regulatory and contractual standards. If deficiencies are cited, the Alliance will issue a corrective action plan (CAP) to the delegate entity to ensure those deficiencies are fully resolved prior to closing out the audit.

The QI Department monitors the language assistance services of its directly contracted provider network to ensure they 1) meet the cultural and linguistic needs of Alliance members and 2) that Alliance providers continuously abide by the standards set forth in the Alliance's Department of Health Care Services (DHCS) contract and all state and federal regulatory requirements. The Alliance takes immediate action when deficiencies are identified, and when necessary, CAPs are created for providers and monitored to ensure ongoing problematic issues are addressed.

PROCEDURE

1. Language Assistance Services Monitoring

1.1. Through facility site reviews, the following are reviewed, and CAPs are put into place per *QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs) and Physical Accessibility Review Surveys (PARS)* as needed:

1.1.1. Twenty-four/seven (24/7) access to telephonic interpreter services for limited English proficiency (LEP) members.

1.1.2. Interpreter services are made available in identified Alliance threshold languages.

1.1.3. Persons providing language interpreter services on site demonstrate training in medical interpretation, including conversational fluency, medical terminology for medical staff and non-medical staff. This must be documented.

1.1.4. The Medical Record Review (MRR) checks if the primary language and linguistic services needs of non- or ~~limited English proficient (~~LEP~~)~~ or deaf or hard of hearing ~~hearing impaired~~ persons as well as any refusal to use professional interpreter services are prominently noted.

1.1.5. Documentation of site personnel receiving information and/or training on cultural and linguistic appropriate services.

1.1.6. Verified evidence of staff training or written cultural and linguistic information on site and explanation of how to use the information.

1.1.7. Confirmation that site personnel have received information and/or training on patient rights and provider obligations under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and/or Section 1557 of the Affordable Care Act. Training content should include information about physical access, reasonable accommodations, policy modifications, and effective communication in healthcare settings.

1.2. The QI Department reviews monthly reports of language services provided to members. The report includes services provided by language, as well as the number of unfilled requests. The Cultural and Linguistic Services Subcommittee (CLSS) and the ~~Health Care~~ Quality Improvement Health Equity Committee (QIHE~~HCQ~~C) review a quarterly language services trending report and make recommendations when there is non-

compliance. Provider or vendor education and/or CAPs may be put into place to address non-compliance and monitored by the CLSS.

1.3. Member experience surveys include questions regarding the experience of limited English proficient members in obtaining interpreter services. Surveys solicit feedback from members regarding coordination of appointments with an interpreter, availability of interpreters who speak the enrollee's preferred language and the quality of interpreter services received.

1.3.1. The Alliance conducts ongoing CG-CAHPS surveys post primary care appointments and annual CAHPS surveys. See Alliance policy *QI-117 Member Satisfaction Survey.*

1.3.1.1. The CG-CAHPS and CAHPS surveys are translated into the Alliance threshold languages and sent in the member's preferred language.

1.3.2. The Alliance also conducts an annual timely access survey focused on language assistance services designed to satisfy § 1300.67.2.2 California Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements. The survey will:

1.3.2.1. Obtain enrollees' perspectives and concerns regarding their experience obtaining timely appointments for health care services.

1.3.2.2. Inform enrollees of their right to obtain an appointment within each of the time-elapsed standards, and their right to receive interpreter services at that appointment.

1.3.2.3. Evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining the enrollee's perspectives and concerns regarding:

1.3.2.3.1. Coordination of appointments with an interpreter;

1.3.2.3.2. Availability of interpreters who speak the enrollee's preferred language; and

1.3.2.3.3. Quality of interpreter services received.

1.3.2.4. Be translated into the enrollee's preferred language, in those situations where the plan is aware of the enrollee's preferred language; and the enrollee's preferred language is one of the top 15 languages spoken by limited English proficient individuals in California as determined by the DHCS~~epartment of Health Care Services~~.

1.3.3. All surveys are sent with the Non-Discrimination Notice and Taglines members are invited to communicate with the Alliance to complete the survey by telephone in their preferred language. The taglines are written in the top 15 languages spoken by limited English proficient individuals as determined by DHCS.

1.4. The Alliance provider satisfaction survey includes questions to receive provider perspectives and concerns with the Alliance language assistance program. Questions include soliciting feedback regarding coordination of appointments with an interpreter, the availability of interpreters based on the needs of an enrollee and the ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.

1.4.1. The Alliance conducts a provider satisfaction survey annually.

1.4.2. See Alliance policy *QI-118 Provider Satisfaction Survey* for details.

1.5. Grievance and Appeals addresses C-&-L grievances according to their timelines (See *G&A-003 Grievance Receipt, Review and Resolution*) and creates a quarterly report of member grievances and appeals related to cultural and linguistic access to services and quality of services. The CLSS and the ~~HCQC~~ QIHEC review a quarterly C-&-L related grievances trending report and make recommendations when there is non-compliance. When necessary, concerns are presented at Joint Operations Meetings (JOMs), providers receive reeducation and/or CAPs are created for providers or vendors and monitored to ensure problematic issues are addressed.

1.6. ~~Potential quality issues (~~PQIs~~)~~ related to quality of language (QOL) may be reported by any member, staff, or provider as a part of our PQI process (See policy and procedure *QI-104 – Potential Quality of Care Issues (PQIs).* QOL PQIs~~S~~ are addressed to ensure quality concerns are investigated, member's interpreter services need and any re-education for providers is addressed. When necessary, CAPs are created for providers or vendors and monitored to ensure problematic issues are addressed.

1.7. Provider Services keeps an updated list of all contracted providers, which include their gender and their language and disability access capacity. Providers report any updates to language and access capacity at least quarterly. Changes are updated monthly in the Alliance data systems and made available to members, potential members, and the public in the Provider Directory online or in print upon request. The CLSS and QIHE ~~HCQ~~C review a quarterly trending report on provider language capacity and make and monitor recommendations for network changes to meet the language needs of the Alliance membership.

2. Bilingual Staff and Vendor Language Capacity. The Alliance also monitors the linguistic capabilities of interpreters and bilingual staff.

2.1. All bilingual employees must complete an assessment prior to offering any interpretation services to members. The Alliance's Human Resources Department conducts the assessments. See *CLS-010 CLS Staff Training* for details. Each assessed employee must:

2.1.1. Demonstrate proficiency in both English and the other language(s) being assessed

2.1.2. Reveal a fundamental knowledge in health care terminology and concepts relevant to health care delivery systems in English and other language(s) being assessed Demonstrate training and education in interpreting ethics, conduct and confidentiality

The Alliance's Human Resources Department maintains a report listing all assessed bilingual employees, their linguistic capabilities, and their qualifications as clinical or non-clinical interpreters. The report is reviewed by the CLSS annually.

2.2. The QI Department monitors the contract with our languages service vendors and requests documentation on capacity and assessment of their interpreter staff.

2.2.1. A receipt/log of all requested interpretation services is kept demonstrating the availability of interpreter services to all members including the interpretative language being requested, date of service, and who provided the interpretation services.

2.2.2. The QI Department requests and reviews a yearly update of certifications of interpreters used through interpreter services vendors.
2.2.3. The Communications and Outreach Department keeps a log of all translated documents and attestation of translation accuracy.

3. Availability of Practitioners to meet the Cultural, Ethnic, Racial and Linguistic needs of members.

3.1. Annually, the Alliance assesses the cultural, ethnic, racial and linguistic needs of its members. Elements assessed include:
3.1.1. Member preferred language
3.1.2. Member Race/Ethnicity
3.1.3. Member Cultural Needs

3.2. Annually, the Alliance assesses the characteristics of network providers and determines if the member needs are met by the network. Elements assessed include:
3.2.1. Provider language capacity
3.2.2. Member survey results
3.2.3. Cultural and linguistic services grievances

3.3. Adjustments are made to the practitioner network to meet the cultural, ethnic, racial, and linguistic needs of members within defined geographical areas. Adjustments may include:
3.3.1. Requiring the completion of the cultural competency and sensitivity training
3.3.2. Making culturally and linguistically appropriate health education materials available to providers
3.3.3. Recruiting practitioners whose cultural and ethnic background are similar to the underrepresented member population.
3.3.4. The Alliance documents areas for improvement and recommendations in the annual "Availability of Practitioners to meet the Cultural Needs and Preferences and Preferences" report.

4. C ~~&~~ ~~L~~ Monitoring Reporting Structure

4.1. The QI Department receives all monitoring reports.
4.2. Reports are presented to the CLSS and forwarded to the QIHE~~HCQ~~C for input and approval.
4.3. A summary of the results is shared with the Community~~Member~~ Advisory Committee (C~~M~~AC) for input and suggested improvements.
4.4. The ~~Quality~~ QI Department collaborates with internal Alliance departments and external providers to provide and implement new approaches or enhancements to existing services to ensure appropriate access and language assistance services and implements CAPs when necessary.

DEFINITIONS / ACRONYMS

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CLS: Cultural and Linguistic Services
CAP" Corrective Action Plan
CAHPS: Consumer Assessment of Healthcare Providers & Systems
CG – CAHPS: Clinician and Group CAHPS survey
CLSS: Cultural and Linguistic Services Subcommittee – a subcommittee of the ~~HCQC~~QIHEC

DHCS: Department for Health Care Services
~~**HCQC**~~**QIHEC**: ~~Health Care~~ Quality Improvement Health Equity Committee – a committee of the Alliance Board of Governors
JOM: Joint Operations Meetings
C~~M~~AC: ~~Member~~Community Advisory Committee
MRR: Medical Record Review
LEP: Limited English Proficiency
PQI: Potential Quality Issues: 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.
QI: Quality Improvement
QOL: Quality of Language

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

REVISION HISTORY

2/13/2015, 3/24/2016, 3/9/2017, 5/25/2017, 10/12/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, 12/19/2023, TBD

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RELATED POLICIES AND PROCEDURES

CLS-008	Member Assessment of Cultural and Linguistic Needs
CLS-009	CLS Program - Contracted Providers
CLS-010	CLS Program - Staff Training
CLS-011	Compliance Monitoring of C & L Program
G&A-003	Grievance Receipt, Review and Resolution
QI-101	Quality Improvement Program
QI-104	Potential Quality of Care Issues
QI-105	Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-117	Member Satisfaction Survey
QI-118	Provider Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

Title 28, CCR 1300.67.04;1300.67.2.2
California Code, Health and Safety Code – HSC 1367.03
DHCS Contract, Exhibit A, Attachment 9, Section 14

MONITORING

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

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-001
Policy Name	Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
Department Name	Case and Disease Management
Department Owner	Director, Case and Disease Management
Lines of Business	All
Effective Date	06/01/2012
Approval/Revision Date	TBD

POLICY STATEMENT

- The Alliance will:
  - Ensure that all Alliance members are identified and, as appropriate, screened, assessed and triaged for Complex Case Management (CCM).
  - Identify members using evidence-based algorithms, utilization data and referrals.
  - Assess identified members for care barriers in order to determine appropriate service delivery.
  - Maintain procedures for documenting the identification, screening, assessment and triage process using a Clinical Information System.
  - Refer members to other services or other case management programs, as appropriate, if the member does not meet the criteria for enrollment in CCM.
- The Alliance delegates CCM for a small proportion of its population. The delegates are required to follow the Department of Health Care regulations, the Department of Health Care Services' contractual obligations, and National committee for Quality Assurance (NCQA) standards. Routine reports are submitted to the Alliance regarding the delegates' performance and, at a minimum, an annual delegation audit of CCM operations is conducted.

PROCEDURE

Scope

This Policy and Procedure addresses the Identification, Screening, Assessment and Triage steps of the Complex Case Management (CCM) process. Definitions of Identification, Screening, Assessment and Triage steps are included within this Policy and Procedure. Clinical Information System

Identification

1. Monthly, the Analytics Department runs a Risk Stratification Population Health Management (PHM) report using medical, mental health, substance use disorder and the Johns Hopkins ACG modeler risk screening data for all members using specific criteria to identify members.

   The Johns Hopkins ACG modeler risk screening scores and reports generated by the AAH Analytics team to identify members who may be appropriate for other Case Management Programs (CCM, Transitions of Care and ECM). Examples of data sources includes but is not limited to:

   a. Hospital Admission/Discharge data
   b. Pharmacy data
   c. Health risk appraisal data
   d. Data collected through the Utilization Management process
   e. Data provided from state agencies – medical assistance category codes
   f. Data supplied by practitioners
   g. Data supplied by member or caregiver

2. The Population Health Report is provided to the Case Management (CM) department monthly for further processing as outlined in this procedure.
3. A list of members who receive and complete Health Risk Assessments and whose scores are high risk will be provided to the Intake Department for further processing. The score for referral to CCM will be reviewed and potentially adjusted on at least an annual basis.
4. On an ongoing basis, CCM referrals will be made from members, caregivers, practitioners, hospital discharge planners, health information line, Utilization Management (UM) staff, and other CM programs for further processing. In addition, CCM members are also identified through the daily hospital discharge report.

   Practitioner data from medical records and concurrent review information is also used to identify members for CCM.

   For transplant members, they may benefit from CCM services as identified by meeting CCM criteria.

   In general, cases should be referred for CCM that meet the following criteria:

   a. Presence of chronic, serious conditions
   b. Multiple ER and hospital admissions

c. Members have multiple chronic medications

d. The amount of resources required for member to regain optimal health or improved functionality is typically extensive.

e. Further information regarding referral policy and procedures is documented in CM-004 - *Care Coordination of Services*.

5. CM staff will:

a. Receive referrals by phone, fax, or e-mail from other departments and enter them into Clinical Information System on a daily basis. Referrals will be entered into the referral summary for further assessment. *Reference CM - 004- Care Coordination of Services.*

b. Create a CCM Referral in Clinical Information System using the monthly Population Health Report.and the Health Risk Appraisal Report.

c. Log the referral in the Clinical Information System with relevant information such as the referral source, urgency of referral, and any corresponding details.

Referral Screening

1. After the Referral is created as outlined above, the referral is assigned out to the appropriate CM staff who will begin the screening process.
2. Referral screening consists of the following

a. Determination of current eligibility of the member.

b. Delegate medical group affiliation

c. If eligible, the CM Staff will review existing programs the member is enrolled in, including CCM.

d. Referrals will be processed according to the following time frames:

i. Urgent – referral opened within 24-72 hours (1 business day).

ii. Routine - referral opened within 5 calendar days.

If at any time, the Manager of CM or designee or 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.

Enrollment

1. Prior to the assessment, the Case Management staff evaluates whether a member should be enrolled in CCM by completing the Complex Criteria Checklist. The checklist is completed based on information gathering from clinical notes, member self-reporting and other data sources, or the individual clinical judgment of the Case Manager. Generally, members are deemed to be eligible for CCM if they exhibit one of the following traits:

a. Medically unstable – uncontrolled or poorly controlled symptoms at significant risk for inpatient admit or ER visit; or new or occasional

exacerbation of symptoms with moderate risk for inpatient admit or ER visit.

b. Necessary resources are not in place or limited or ineffective resources are in place.

c. Care requires complex or moderate coordination with multiple providers involved and member/caretaker education/teaching is needed.

d. Non-compliance with treatment plan requiring significant or ongoing monitoring.

e. Case management opportunities exist for the member. In general, there will always be CM opportunities; however, the CM will determine if the opportunities are such that warrant CCM resources or other Alliance resources may be more appropriate. The enrollment of a member into CCM is based on individual clinical judgment of the Case Manager and member's willingness to enroll. See CM - 004 – *Care Coordination of Services*.

2. After documenting the decision to enroll the member, but prior to enrolling the member in the CCM program, the Case Management staff will explain CCM services to the member and obtain consent. CCM service explanation will include:

   a. A description of the proposed services provided and the benefits of the program, i.e., designated nurse, collaborative setting of and attainment of goals, assistance with coordinating benefits, etc.

   b. The program is offered at no-cost to the member.

   c. The right of the member to refuse case management services, alternatives to CCM and the consequences, if any, of refusing services.

   d. Confidentiality of information per the Alliance Notice of Privacy Practices which allows for sharing of information with practitioners for treatment, quality of care and/or payment purposes.

   e. The right for the members to file a grievance.

3. The decision by the member to participate in the CCM program will be recorded on the assessment form in the Clinical Information System or in a Consent Note in the Clinical Information System. The Care Plan process and upcoming outreach attempts are also communicated to the member through telephone outreach and via an enrollment letter.

Assessment

1. CM staff assignments of assessments will be made based on work-load and specialization.

   a. CCM cases meeting Disease Management (DM) criteria will be tasked to CMs designated for DM.

b. For transplant members, an additional transplant assessment will be completed to identify any additional needs related to the member's transplant.

2. The information gathered from these assessments is used to identify problems that the Case Manager will need to add to the member's care plan.
3. Initial member telephonic outreach includes at least 3 attempts made during working hours Monday through Friday from 8:00 AM-5:00 PM within the priority standards outlined above. If CM staff is still not able to reach the member, a letter is mailed to the member as a third attempt using the priority standards.
4. An assessment will be started on each member within 30 days of identification or referral from screening and will include the following:
    i. Evaluation of the member's health status, including any condition-specific issues and comorbidities.
    ii. Review and documentation of complete clinical, medication and utilization history. If this information is not present in the Clinical Information System, the CM shall review the external utilization data source.
    iii. Assessment of the member's functional capacity using specific questions to assess the activities of daily living (ADLs), including the member's eating, bathing and mobility capacity.
    iv. Assessment questions related to impairment of cognitive functions, including the ability to communicate, understand instructions and process information about their illness.
    v. Screening for depression, anxiety, alcohol, drug use and psychosocial issues.
    vi. Assessment of life planning activities (Advance Directives, Living Will and Power of Attorney) or documentation explaining why this assessment was not appropriate. If appropriate, member will be mailed information regarding life planning activities, along with beneficial follow up instructions.
    vii. Confirmation or collection of information from the member on preferences for communication, religious and cultural preferences that may impact care delivery.
    viii. Assessment of language, vision, hearing or other impairments impacting care delivery and communication.
    ix. Availability of caregiver resources and their involvement with the member.
    x. Assessment of the available benefits and needs for community and financial resources.
    xi. Assessment of Preventive Health screening and reminders appropriate to age and gender.

5. At any time during the Assessment process, the case will be referred to a Behavioral Health Clinician if the case meets the following criteria:
    a. Behavioral Health (BH) diagnosis meeting identification criteria without acute co-morbidities.
    b. BH diagnosis that meets identification criteria with medical co-morbidities well managed
    c. Members with BH diagnosis of such acuity that the member is unable to understand or comply with medical treatment plans. Examples may include: drug or alcohol dependency, major depressive disorder and bipolar disorders.
    d. For members who do not meet the above criteria, Case Management will continue to provide all necessary case management services.

    Refer to policy and procedure *CM-004 - Care Coordination of Services*, for the details on making behavioral health referrals.

The evaluation for enrollment, completion of the Assessment, and scheduling of follow up appointments, as applicable completes the CCM Identification, Screening, Enrollment and Assessment processes.

DEFINITIONS/ACRONYMS

Active Complex Case Management: A member is defined as in Active Complex Case Management at the time an Assessment is completed and the member is entered into complex case management by the case manager

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 creating a care plan. There are numerous assessment tools pre-built in the Clinical Information System that can be used to compile data.

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.

Case Identification: Identification is the initial process of selecting cases for review for complex case management. Identification is the first step in the process where members are identified from data sources and referrals are taken for members meeting defined criteria. This step does not involve clinical judgment to identify the people who meet defined criteria.

Complex Case Management (CCM): The systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and need help navigating the system to facilitate appropriate delivery of care and services

CCM Enrollment: Decision making to determine whether the member proceeds to Care Plan Development and Management. The decision is based on several factors. These include the member's agreement to participate, the acuity score, and/or clinician judgment based on the individual circumstances of the case.

Referral Screening: Referral Screening is the process where an initial non-clinical decision is made to determine whether a member proceeds to the Enrollment stage of processing for Complex Case Management. This entails screening against identification criteria, eligibility status and whether the member is already in existing programs.

AFFECTED DEPARTMENTS/PARTIES

HealthCare Analytics
Provider Relations
Utilization Management
Quality Oversight
Case and Disease Management
Alliance Members
Alliance Delegated Groups
Alliance Directly Contracted Physicians

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Complex Case Management (CCM) Program Description
CM-002 Policy and Procedure, Complex Case Management (CCM) Plan Development and Management
CM-004 Policy and Procedure, Care Coordination of Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Population Health Report
Health Risk Assessment
How to Submit a Referral (training document)

REVISION HISTORY

12/05/2012, 3/1/2016, 09/06/2018, 5/21/2020, 5/21/2021, 9/16/2021**, 0**3/22/2022, 1/11/2023

REFERENCES

1. National Committee on Quality Assurance Quality Improvement QI 5: Complex Case Management

MONITORING

1. CCM Identification and Screening is monitored by the following:
    a. Conversion rates by referral source
    b. Data entry auditing of Intake and CM staff
    c. Time frames to complete identification, screening, assessment and triage tasks.
    ~~d.~~ Member grievances specific to identification, screening, assessment and triage process

d.

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POLICY AND PROCEDURE

Policy Number	CM-001
Policy Name	Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
Department Name	Case and Disease Management
Department Owner	Director, Case and Disease Management
Lines of Business	All
Effective Date	06/01/2012
Approval/Revision Date	~~01/11/2023~~TBD

POLICY STATEMENT

- The Alliance will:
  - Ensure that all Alliance members are identified and, as appropriate, screened, assessed and triaged for Complex Case Management (CCM).
  - Identify members using evidence-based algorithms, utilization data and referrals.
  - Assess identified members for care barriers in order to determine appropriate service delivery.
  - Maintain procedures for documenting the identification, screening, assessment and triage process using a Clinical Information System.
  - Refer members to other services or other case management programs, as appropriate, if the member does not meet the criteria for enrollment in CCM.
- The Alliance delegates CCM for a small proportion of its population. The delegates are required to follow the Department of Health Care regulations, the Department of Health Care Services' contractual obligations, and National committee for Quality Assurance (NCQA) standards. Routine reports are submitted to the Alliance regarding the delegates' performance and, at a minimum, an annual delegation audit of CCM operations is conducted.

PROCEDURE

Scope

This Policy and Procedure addresses the Identification, Screening, Assessment and Triage steps of the Complex Case Management (CCM) process. Definitions of Identification, Screening, Assessment and Triage steps are included within this Policy and Procedure. Clinical Information System

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2. The Population Health Report is provided to the Case Management (CM) department monthly for further processing as outlined in this procedure.
3. A list of members who receive and complete Health Risk Assessments and whose scores are high risk will be provided to the Intake Department for further processing. The score for referral to CCM will be reviewed and potentially adjusted on at least an annual basis.
4. On an ongoing basis, CCM referrals will be made from members, caregivers, practitioners, hospital discharge planners, health information line, Utilization Management (UM) staff, and other CM programs for further processing. In addition, CCM members are also identified through the daily hospital discharge report.

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d. The amount of resources required for member to regain optimal health or improved functionality is typically extensive.

e. Further information regarding referral policy and procedures is documented in CM-004 - *Care Coordination of Services*.

5. CM staff will:

a. Receive referrals by phone, fax, or e-mail from other departments and enter them into Clinical Information System on a daily basis. Referrals will be entered into the referral summary for further assessment. *Reference CM - 004- Care Coordination of Services.*

b. Create a CCM Referral in Clinical Information System using the monthly Population Health Report.and the Health Risk Appraisal Report.

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If at any time, the Manager of CM or designee or 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.

Enrollment

1. Prior to the assessment, the Case Management staff evaluates whether a member should be enrolled in CCM by completing the Complex Criteria Checklist. The checklist is completed based on information gathering from clinical notes, member self-reporting and other data sources, or the individual clinical judgment of the Case Manager. Generally, members are deemed to be eligible for CCM if they exhibit one of the following traits:

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2. After documenting the decision to enroll the member, but prior to enrolling the member in the CCM program, the Case Management staff will explain CCM services to the member and obtain consent. CCM service explanation will include:

   a. A description of the proposed services provided and the benefits of the program, i.e., designated nurse, collaborative setting of and attainment of goals, assistance with coordinating benefits, etc.

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   c. The right of the member to refuse case management services, alternatives to CCM and the consequences, if any, of refusing services.

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Assessment

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   a. CCM cases meeting Disease Management (DM) criteria will be tasked to CMs designated for DM.

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    d. For members who do not meet the above criteria, Case Management will continue to provide all necessary case management services.

    Refer to policy and procedure *CM-004 - Care Coordination of Services*, for the details on making behavioral health referrals.

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Complex Case Management (CCM): The systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and need help navigating the system to facilitate appropriate delivery of care and services

CCM Enrollment: Decision making to determine whether the member proceeds to Care Plan Development and Management. The decision is based on several factors. These include the member's agreement to participate, the acuity score, and/or clinician judgment based on the individual circumstances of the case.

Referral Screening: Referral Screening is the process where an initial non-clinical decision is made to determine whether a member proceeds to the Enrollment stage of processing for Complex Case Management. This entails screening against identification criteria, eligibility status and whether the member is already in existing programs.

AFFECTED DEPARTMENTS/PARTIES

HealthCare Analytics
Provider Relations
Utilization Management
Quality Oversight
Case and Disease Management
Alliance Members
Alliance Delegated Groups
Alliance Directly Contracted Physicians

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Complex Case Management (CCM) Program Description
CM-002 Policy and Procedure, Complex Case Management (CCM) Plan Development and Management
CM-004 Policy and Procedure, Care Coordination of Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Population Health Report
Health Risk Assessment
How to Submit a Referral (training document)

REVISION HISTORY

12/05/2012, 3/1/2016, 09/06/2018, 5/21/2020, 5/21/2021, 9/16/2021**, 0**3/22/2022, 1/11/2023

REFERENCES

1. National Committee on Quality Assurance Quality Improvement QI 5: Complex Case Management

MONITORING

1. CCM Identification and Screening is monitored by the following:
    a. Conversion rates by referral source
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POLICY AND PROCEDURE

Policy Number	CM-004
Policy Name	Care Coordination of Services
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal and Group Care
Effective Date	06/01/2012
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Care Coordination (CC) services are available to all Alliance members. The Case Management (CM) Referral process allows for timely access to these services. The CC process provides access to other services when Complex Case Management (CCM) may not best serve the member or additional services are needed.

All referrals to CM shall be directed to CM/DM Intake. All referrals to CM will be documented within the Clinical Information System. CM referrals may be received by any source and by phone, fax, e-mail, or direct referral entry into the Clinical Information System by Alliance staff.

The process will be communicated to members, caregivers, and providers when a referral to other services is recommended. The Alliance CM staff will continue to coordinate the transition for the members until they are fully transitioned to the other agencies.

The Alliance maintains workflows and processes to ensure no duplication of services occur. When duplication is brought to the attention of the CM team member, efforts are made to collaborate and transition as appropriate.

The Alliance implements information-sharing processes and referral support infrastructure. The Alliance ensures appropriate sharing and exchange of member information and medical records by providers and the plan in accordance with professional standards and state and federal privacy laws and regulations

PROCEDURE

Scope

This Policy and Procedure addresses referrals into Care Coordination as well as referrals from CM to other Health Plan, practitioner, community, and other services as dictated by the needs of the member.

This policy does not address UM referrals, standing referrals and referrals to specialists which are covered under UM Policy and Procedures.

Referral Screening

1. CM staff will:
    a. Receive referrals by phone, fax, or e-mail from other departments and enter them into Clinical Information System on a daily basis. Referrals will be entered into the referral summary for further assessment. *Reference CM -001-Complex Case Management (CCM) Screening, Enrollment and Assessment*
    b. Log the referral in the Clinical Information System with relevant information such as the referral source, urgency of referral (if appropriate), and any corresponding details.
    c. Cases identified from the Risk Stratification Population Health Management (PHM) report are used to create a CCM Referral in Clinical Information System.
    d. Review direct referrals received via the Clinical Information System Provider Portal to ensure appropriate program is selected to address the identified concerns:
        i. Care coordination concerns
        ii. Complex medical care concerns
        iii. Disease Management, Asthma, Diabetes, COPD
        iv. Managed Long Term Services – CBAS, Custodial Care
        v. Behavioral Health Referral
2. After the Referral is created as outlined above, the CM staff will begin the screening process.
3. Referral screening consists of the following
    a. Determination of current eligibility of the member.
    b. Delegate medical group affiliation
    c. If eligible, the CM Staff will review existing programs the member is enrolled in, including CCM.

d. Referrals will be processed according to the following time frames:

i. Urgent – referral opened within 24 – 72 hours (1 business day).

ii. Routine – referral opened within 5 calendar days.

If at any time, the Manager of CM or designee or 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.

Case Manager Role in Care Coordination Case

1. CM staff assignments will be made based on workload and specialization.
    a. CM referrals meeting Care Coordination criteria will be assigned to appropriate CC staff (Nurse Case Manager, Health Navigator, or Social Worker) for assessment.
    b. The CM Staff will assess for and coordinate with the appropriate agency to ensure there is no duplication of services. (This includes members receiving TCM.)
2. The CC staff shall contact the member to assess the service needs. The CC staff will provide care coordination and Basic Population Health Management (BPHM) for the member in conjunction with the PCP if the member is engaged with the PCP.

    Provision of care coordination and BPHM includes but is not limited to:

    a. Ensuring that each member has an ongoing source of care that is appropriate, ongoing and timely to meet the member's needs;
    b. Ensuring members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;
    c. Ensuring that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with the CC Staff;
    d. Ensuring each Member receives all needed preventive services in partnership with the Member's assigned PCP and in partnership with the Plan's Quality department initiatives;
    e. Ensuring efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from Out-of-Network Providers;
    f. Facilitating access to care for Members by helping to make appointments, arranging transportation;

g. Ensuring member health education on the importance of Primary Care for members who have not had any contact with their PCP or have not been seen within the last 12 months, particularly members less than 21 years of age;

h. Arranging of services not directly related to medical needs, i.e., non-medical transportation, and community resources;

i. Referring a member for In-Home Supportive Services (IHSS);

j. Reassing as necessary per the population RSS and Risk Tiering requirements;

k. Continuing to provide coordination of care and BPHM based on member needs when a member is receiving IHSS services;

l. Coordinating health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (such as Targeted Case Management and Specialty Mental Health Services), with external entities outside of the Plan's Network, with Community Supports, and other community-based resources, even if they are not covered services;

m. Coordinating warm hand-offs to other public benefits programs including CalWORKs, CalFresh, WIC, Early Intervention Services, SSI, and all other programs;

n. Assisting members, members' parents, family members, legal guardians, authorized representatives, caregivers, and authorized support persons with navigating health delivery systems, including the Plan's subcontractor and downstream subcontractor networks, to access covered services as well as services not covered;

o. Providing members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

p. Communicating to members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all the care coordination provided to members, as appropriate;

q. Facilitating exchange of necessary member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable; and

r. Ensuring no duplication of services occur

3. The CC staff provides care coordination for members not meeting criteria for CCM. The CC staff also assists with components of CCM cases by arranging for services per an identified Complex Care Plan. Examples include, but are not limited to, evaluating the member for further needs, and arranging services

for a specific identified care gap such as medication affordability or environmental safety. The assistance that the CC staff provides towards a CCM case is generally of a short-term nature and is directed as specified in the Plan of Care.

4. The CC staff shall arrange these services and document such within the Clinical Information System.
5. CC staff may also assist CM staff with care coordination needs. Referrals are made from the CM process to the following:
    a. Behavioral Health Clinician. Referrals shall be made to the Behavioral Health Clinician for behavioral health CM services for Medi-Cal members with low to moderate risk members and Alameda County program for moderate to high-risk members. Case conferences shall be arranged as necessary for those with co-morbid mental and physical health conditions. The Alliance will provide care coordination services for any medical care and services in collaboration with the Behavioral Health Clinician.
        i. For members without significant medical/surgical issues, the members will be managed by the Behavior Health Clinician.
    b. Utilization Management (UM). Prior authorization functions are handled by the UM department. All requests for authorizations shall be directed to the UM department following standard procedures.
    c. Community Resources. The CM staff can arrange directly for services via known community resources or request assistance from the Health Navigator in doing so. The Alliance has a list of community resources available to assist the CMs and others in providing community services.
    d. Other services or providers as appropriate to the member's Plan of Care.
6. All referrals from CM staff require follow-up unless specified as an optional recommendation by the CM staff. The CM staff will document the schedule for follow-up within the system of record. The follow up due date will not exceed 30 calendar days.

Referral Processing Timeframes

1. The CC designee processes referral requests within one working day from receipt of the request for care coordination services.
2. Recipients of the CC referral shall open the referral according to the case priority classification:
    a. Urgent – referral opened and started within 1 working day
    b. Routine – referral opened and started within 5 calendar days

c. Unknown at time of referral.

3. Follow-up to referrals will be made as specified by the referral need, but no later than 30 calendar days after the referral is made.

Children with Special Health Care Needs (CSHCN)

1. For Children with Special Health Care Needs (CSHCN) receive a comprehensive assessment of health related needs.
2. Once the assessment is complete, the CM staff will assist with ensuring and monitoring timely access (including but not limited) to:
    a. Pediatric specialists
    b. Sub-specialists
    c. Ancillary therapists
    d. Transportation
    e. DME and supplies

These may include assignment to a specialist as a PCP, standing referrals or other methods.

3. As appropriate, members will be assessed for California's Children Services (CCS) and Developmental Disabilities (DD) and referrals will be made as needed.

Direct Observed Therapy for TB

1. The Plan has an MOU in place with the LHD to ensure joint case management and care coordination for members with active TB.

2. Members with active TB and members who have treatment resistance or non-compliance issues will be referred to the TB control office of the LHD for DOT.

3. CM staff will collaborate/joint case manage with the LHD TB Control Officer.

Coordination with IHSS

AAH maintains procedures for identifying and referring eligible Members to the county IHSS program. AAH's procedures address the following requirements:

1. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;

2. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies AAH that IHSS is no longer needed for the Member;

3. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;

4. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements

5. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.

6. To facilitate coordination, AAH has MOUs with each county IHSS agency within AAH's Service Area in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*). The MOU delineates the roles and responsibilities of AAH and IHSS in providing IHSS to the Members.

7. Regular communication with IHSS regarding member status for open medical issues and related social issues.

Referrals to CCM

1. CCM referrals may originate from any source including, but not limited to, self-referral, caregiver, Primary Care Providers or Specialists, discharge planners at medical facilities, health information line referrals, and internal department referrals such as UM, Disease Management and Member Services.
2. For CC cases opened initially as care coordination, but after the initial or subsequent CM staff interventions is found to be of a higher risk, the CM staff will contact the Department Management or CCM staff to discuss case needs.
3. Referrals that are selected for CCM are not diagnosis-specific, but rather based on the following general criteria:
    a. The degree and complexity of the member's illness is typically severe.
    b. The level of management necessary is typically intensive.
    c. The amount of resources required for the member to regain optimal health or improved functionality is typically extensive.
4. If case is to be referred for CCM, information needed for a CCM referral includes:
    a. Referral or data source
    b. Date referral received by Intake. If secondary referral, document initial contact information and date.
    c. Member information
    d. Reason for referral
    e. Additional information, as necessary.

A CCM Referral Form is at Attachment 1. However, a referral form is not necessary, and all information can be taken by phone or any other means.

5. Upon receipt of the necessary information for a referral, the CM/DM designated staff shall document the referral in the member's file by entering the information into the referral summary screen in the Clinical Information System. Details on data entry are described in *CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment*.

1. **Referrals from CCM to CC**

During the CCM Assessment and Triage phase or before a case is opened to CCM, the Manager of CM/DM or the assigned CM staff may refer the case to a Health Navigator instead of a CM if the case is determined to be of low complexity and member's medical history is of low risk. The assigned CM staff will access the appropriate section on the General Assessment and record the referral decision and create a task as outlined in *CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening Enrollment and Assessment.*

DEFINITIONS

Children with Special Health Care Needs: members who are or at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type or amount beyond that generally required by children.

Referral: The arrangement for services by another care provider 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

Attachment 1. Referral Form
Complex Case Management (CCM) Program Description
CM-001 Policy and Procedure, CCM Identification Screening Enrollment and Assessment

CM-004 Care Coordination of Services

CM-002 Policy and Procedure, Complex Case Management (CCM) Plan Development and Management
CM-004 Policy and Procedure, Management (CCM) Plan Evaluation and Closure

REVISION HISTORY

12/05/2012, 03/01/2016, 03/21/2019, 04/16/2019, 05/21/2020, 05/21/2021, 9/16/2021, 3/22/2022, 2/24/2023

REFERENCES

1. NCQA QI 5 Element C
2. CCM Referral
3. CM-001, Policy and Procedure, Complex Case Management Identification, Screening, Enrollment and Assessment
4. CM-002 Policy and Procedure, Complex Case Management (CCM) Plan Development and Management

MONITORING

Referrals to and from CCM are monitored through:

a. Number of referrals to CCM from referral sources.
b. Case files audits for referrals from CCM.
c. Performance against referral timeliness standards

Monitoring for IHSS referrals:

a. Members receiving IHSS will be tracked and coordinating services will continue until IHSS notifies the Alliance that IHSS is no longer needed for the member.

ALAMEDA Alliance FOR HEALTH

Case Management (CM) Program Referral Form

Thank you for your interest in referring your Alameda Alliance for Health (Alliance) patient to our Case Management (CM) program.

INSTRUCTIONS

Please return the completed form via mail, email or fax:

Alameda Alliance for Health
ATTN: Case and Disease Management Department (CMDM)
1240 South Loop Road, Alameda, CA 94502
Email: **deptcmdm@alamedaalliance.org**
Fax: **1.510.747.4130**

PLEASE NOTE: The Alliance will directly notify the member which CM program can provide them services. For questions, please contact the Alliance CMDM Department via email or call toll-free at **1.877.251.9612**.

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

Name: _____
Facility/Clinic Name: _____
Phone Number: _____ Fax Number: _____
Referral Source: ☐ Community Partner ☐ Hospital ☐ PCP ☐ Specialty Provider
☐ Other: _____

SECTION 2: PATIENT INFORMATION

Last Name: _____ First Name: _____
Alliance Member ID #: _____ Date of Birth (MM/DD/YYYY): _____
Phone Number: _____ Sex: ☐ Female ☐ Male
Address *(or location i.e. under 5th St. bridge)*: _____
City: _____ State: _____ Zip: _____

SECTION 3: REFERRAL INFORMATION

Referral for (please choose one (1) per referral): ☐ RN ☐ MSW ☐ Health Navigator ☐ Other
Please Note: Health Navigators are able to assist with basic case management services (e.g. DME, appointments).
☐ Patient has been informed of referral.

Reason for referral (*please attach supporting/clinical documents **up to the past 30 days***).
For behavioral health referrals, please call Beacon toll-free at **1.855.856.0577**.

Situation/background (including past medical history (PMH), if applicable):

Specific action item request(s):

This fax (and any attachments) is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by telephone or fax and destroy all copies of the original message (and any attachments).

For all other member requests, please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567**.

CMDM_PRVDRS_ PROG REF FORM 03/2021

POLICY AND PROCEDURE

Policy Number	CM-004
Policy Name	Care Coordination of Services
Department Name	Case and Disease Management
Department Officer	~~Director, Health Care Services~~Chief Medical Officer
Policy Owner	~~Chief Medical Officer~~Director, Social Determinants of Health
Line(s) of Business	Medi-Cal and Group Care
Effective Date	06/01/2012
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	
Compliance Committee Approval Date	~~01/11/2023~~TBD

POLICY STATEMENT

Care Coordination (CC) services are available to all Alliance members. The Case Management (CM) Referral process allows for timely access to these services. The CC process provides access to other services when Complex Case Management (CCM) may not best serve the member or additional services are needed.

All referrals to CM shall be directed to CM/DM Intake. All referrals to CM will be documented within the Clinical Information System. CM referrals may be received by any source and by phone, fax, e-mail, or direct referral entry into the Clinical Information System by Alliance staff.

The process will be communicated to members, caregivers, and providers when a referral to other services is recommended. The Alliance CM staff will continue to coordinate the transition for the members until they are fully transitioned to the other agencies.

The Alliance maintains workflows and processes to ensure no duplication of services occur. When duplication is brought to the attention of the CM team member, efforts are made to collaborate and transition as appropriate.

The Alliance implements information-sharing processes and referral support infrastructure. The Alliance ensures appropriate sharing and exchange of member information and medical records by providers and the plan in accordance with professional standards and state and federal privacy laws and regulations

PROCEDURE

Scope

This Policy and Procedure addresses referrals into Care Coordination as well as referrals from CM to other Health Plan, practitioner, community, and other services as dictated by the needs of the member.

This policy does not address UM referrals, standing referrals and referrals to specialists which are covered under UM Policy and Procedures.

Referral Screening

1. CM staff will:
    a. Receive referrals by phone, fax, or e-mail from other departments and enter them into Clinical Information System on a daily basis. Referrals will be entered into the referral summary for further assessment. *Reference CM -001-Complex Case Management (CCM) Screening, Enrollment and Assessment*
    b. Log the referral in the Clinical Information System with relevant information such as the referral source, urgency of referral (if appropriate), and any corresponding details.
    c. Cases identified from the Risk Stratification Population Health Management (PHM) report are used to create a CCM Referral in Clinical Information System.
    d. Review direct referrals received via the Clinical Information System Provider Portal to ensure appropriate program is selected to address the identified concerns:
        i. Care coordination concerns
        ii. Complex medical care concerns
        iii. Disease Management, Asthma, Diabetes, COPD
        iv. Managed Long Term Services – CBAS, Custodial Care
        v. Behavioral Health Referral
2. After the Referral is created as outlined above, the CM staff will begin the screening process.
3. Referral screening consists of the following
    a. Determination of current eligibility of the member.
    b. Delegate medical group affiliation
    c. If eligible, the CM Staff will review existing programs the member is enrolled in, including CCM.

d. Referrals will be processed according to the following time frames:

i. Urgent – referral opened within 24 – 72 hours (1 business day).

ii. Routine – referral opened within 5 calendar days.

If at any time, the Manager of CM or designee or 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.

~~Care Coordination~~Case Manager Role in Care Coordination Case

1. CM staff assignments ~~of assessments~~ will be made based on workload and specialization.

~~1.~~ CM referrals meeting ~~:~~

a. Care Ceoordination criteria will be assigned to ~~the~~ appropriate CC ~~Care Coordination~~ staff (Nurse Case Manager, Health Navigator, or Social Worker) for assessment.

~~a.~~b. The CM Staff will assess for and coordinate with the appropriate agency to ensure there is no duplication of services. (This includes members receiving TCM.)

2. The CC ~~Health Navigator~~staff shall contact the member to assess the service needs. The CC staff will provide care coordination and Basic Population Health Management (BPHM) for the member in conjunction with the PCP if the member is engaged with the PCP.

Provision of care coordination and BPHM includes but is not limited to:

a. Ensuring that each member has an ongoing source of care that is appropriate, ongoing and timely to meet the member's needs;

b. Ensuring members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;

c. Ensuring that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with the CC Staff;

d. Ensuring each Member receives all needed preventive services in partnership with the Member's assigned PCP and in partnership with the Plan's Quality department initiatives;

e. Ensuring efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from Out-of-Network Providers;

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f. Facilitating access to care for Members by helping to make appointments, arranging transportation;

g. Ensuring member health education on the importance of Primary Care for members who have not had any contact with their PCP or have not been seen within the last 12 months, particularly members less than 21 years of age;

~~b. Health Navigators~~Arranging ~~may arrange for~~ of services not directly related to medical needs, i.e., non-medical transportation, and community resources;

h.

~~c. This includes but is not limited to referring~~Referring a member for In-Home Supportive Services (IHSS);

i.

~~d. Members will be reassessed~~Reassing as necessary per the population RSS and Risk Tiering requirements;~~.~~

j.

k. ~~When a member is provided IHSS services,~~ Continuing to provide coordination of care and ~~Basic Population Health Management (~~BPHM ~~) will continue to be provided~~ based on member needs when a member is receiving IHSS services;~~.~~

l. Coordinating health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (such as Targeted Case Management and Specialty Mental Health Services), with external entities outside of the Plan's Network, with Community Supports, and other community-based resources, even if they are not covered services;

m. Coordinating warm hand-offs to other public benefits programs including CalWORKs, CalFresh, WIC, Early Intervention Services, SSI, and all other programs;

n. Assisting members, members' parents, family members, legal guardians, authorized representatives, caregivers, and authorized support persons with navigating health delivery systems, including the Plan's subcontractor and downstream subcontractor networks, to access covered services as well as services not covered;

o. Providing members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

p. Communicating to members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all the care coordination provided to members, as appropriate;

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q. Facilitating exchange of necessary member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable; and

~~1.~~r. Ensuring no duplication of services occur

~~2.~~3. The ~~Health Navigator~~CC staff provides ~~case management~~care coordination for members not meeting criteria for CCM. The ~~Health Navigator~~CC staff also assists ~~the CM staff~~ with components of CCM cases by arranging for services per an identified Complex Care Plan. Examples include, but are not limited to, evaluating the member for further needs, and arranging services for a specific identified care gap such as medication affordability or environmental safety. The assistance that the ~~Health Navigator~~CC staff provides ~~to the member~~towards a CCM case is generally of a short-term nature and is directed as specified in the Plan of Care.

~~3.~~4. The ~~Health Navigator~~CC staff shall arrange these services and document such within the Clinical Information System.

5. ~~Health Navigators~~CC staff may also assist CM staff with care coordination needs. Referrals are made from the CM process to the following:

~~4.~~

a. Behavioral Health Clinician. Referrals shall be made to the Behavioral Health Clinician for behavioral health CM services for Medi-Cal members with low to moderate risk members and Alameda County program for moderate to high-risk members. Case conferences shall be arranged as necessary for those with co-morbid mental and physical health conditions. The Alliance will provide care coordination services for any medical care and services in collaboration with the Behavioral Health Clinician.

   i. For members without significant medical/surgical issues, the members will be managed by the Behavior Health Clinician.

b. Utilization Management (UM). Prior authorization functions are handled by the UM department. All requests for authorizations shall be directed to the UM department following standard procedures.

c. Community Resources. The CM staff can arrange directly for services via known community resources or request assistance from the Health Navigator in doing so. The Alliance has a list of community resources available to assist the CMs and others in providing community services.

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Coordination with IHSS

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2. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies AAH that IHSS is no longer needed for the Member;
3. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;
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~~1.~~

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~~f~~

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   e. Additional information, as necessary.

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12/05/2012, 03/01/2016, 03/21/2019, 04/16/2019, 05/21/2020, 05/21/2021, 9/16/2021, 3/22/2022, 2/24/2023

REFERENCES

1. NCQA QI 5 Element C
2. CCM Referral
3. CM-001, Policy and Procedure, Complex Case Management Identification, Screening, Enrollment and Assessment
4. CM-002 Policy and Procedure, Complex Case Management (CCM) Plan Development and Management

MONITORING

Referrals to and from CCM are monitored through:

a. Number of referrals to CCM from referral sources.
b. Case files audits for referrals from CCM.
c. Performance against referral timeliness standards

Monitoring for IHSS referrals:

a. Members receiving IHSS will be tracked and coordinating services will continue until IHSS notifies the Alliance that IHSS is no longer needed for the member.

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ATTACHMENT 1

ALAMEDA Alliance FOR HEALTH

Case Management (CM) Program Referral Form

Thank you for your interest in referring your Alameda Alliance for Health (Alliance) patient to our Case Management (CM) program.

INSTRUCTIONS

Please return the completed form via mail, email or fax:
Alameda Alliance for Health
ATTN: Case and Disease Management Department (CMDM)
1240 South Loop Road, Alameda, CA 94502
Email: **deptcmdm@alamedaalliance.org**
Fax: **1.510.747.4130**

PLEASE NOTE: The Alliance will directly notify the member which CM program can provide them services. For questions, please contact the Alliance CMDM Department via email or call toll-free at **1.877.251.9612**.

REQUEST DATE (MM/DD/YYYY):

SECTION 1: REFERRING PROVIDER INFORMATION

Name:
Facility/Clinic Name:
Phone Number: Fax Number:
Referral Source: ☐ Community Partner ☐ Hospital ☐ PCP ☐ Specialty Provider
☐ Other:

SECTION 2: PATIENT INFORMATION

Last Name: First Name:
Alliance Member ID #: Date of Birth (MM/DD/YYYY):
Phone Number: Sex: ☐ Female ☐ Male
Address *(or location i.e. under 5th St. bridge)*:
City: State: Zip:

SECTION 3: REFERRAL INFORMATION

Referral for (please choose one (1) per referral): ☐ RN ☐ MSW ☐ Health Navigator ☐ Other
Please Note: Health Navigators are able to assist with basic case management services (e.g. DME, appointments).
☐ Patient has been informed of referral.

Reason for referral (*please attach supporting/clinical documents **up to the past 30 days***).
For behavioral health referrals, please call Beacon toll-free at **1.855.856.0577**.

Situation/background (including past medical history (PMH), if applicable):

Specific action item request(s):

This fax (and any attachments) is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by telephone or fax and destroy all copies of the original message (and any attachments).

For all other member requests, please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm at **1.510.747.4567**.

CMDM_PRVDRS_ PROG REF FORM 03/2021

POLICY AND PROCEDURE

Policy Number	CM-009
Policy Name	Enhanced Care Management Program Infrastructure
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

Alameda Alliance for Health (AAH) leverages existing relationships and communications with our provider network to facilitate care planning, care coordination, and care transition coordination as stated in the Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) Program Guide.

AAH's ECM is structured as a network which includes AAH contracted ECM Providers, and relationships with other Community-Based Organizations and providers to provide linkages to healthcare, community, and social support services.

The ECM Provider serves as the primary coordinator for overseeing the patient-centered care for assigned ECM eligible/enrolled members.

AAH will perform duties/responsibilities as outlined per the DHCS CalAIM Enhanced Care Management Program Guide.

AAH requires our subcontracted plans (delegates) use the same process for informing members, family member(s), guardian, caregiver and/or other authorized support person(s) about ECM, how to request ECM and that the status of the request is communicated back to inquiring party.

PROCEDURE

1.0 The ECM network will be developed and continually monitored to meet the following goals:

1.1 Ensure sufficient ECM funds are available to support care management at the point of care in the community.

1.2 Ensure that providers with experience serving frequent utilizers of health services and individuals experiencing homelessness are available.
1.3 Leverage existing county and community provider care management infrastructure and experience.
1.4 Forge new relationships with community provider care-management entities.
1.5 Utilize community health workers in appropriate roles.

2.0 The goal of ECM includes:

2.1 Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based services & supports, palliative care, and social support needs, including housing;

2.1.1 In order to identify risks and improve member outcomes, the ECM Provider is responsible for conducting a Health Action Plan, defined as a comprehensive risk assessment and care plan, within ninety (90) calendar days of the member's enrollment into the ECM.

2.2 Reducing avoidable health costs, including hospital admissions/readmission, Emergency Department (ED) visits, and nursing facility stays.

2.2.1 AAH manages and monitors key metrics reports compiled by the AAH Analytics team. The ECM dashboard is distributed to the appropriate ECM Provider on a routine basis.

2.3 AAH performs the following duties/responsibilities:

2.3.1 AAH will inform the providers and entities who serve the Members of this Population of Focus as follows:

2.3.1.1 Inclusion of ECM information in Quarterly Provider Packets sent to providers either through mail or delivered in-person

2.3.1.2 Posting of ECM materials and announcements on the Alliance website

2.3.1.3 Instructions on to whom/how to initiate ECM referrals-(referral form) on Alliance website

2.3.1.4 Instructions on how to contact Alliance Case Management Department on the Alliance website

2.3.1.5 Newsletter on Alliance website

2.3.1.6 In addition, AAH will be hosting community-based stakeholder meetings to include nursing homes, home health agencies, Community Based Adult Services (CBAS) Providers, the Senior Services Coalition, Alameda County Health Care Services Agency (HCSA), and Centers for Independent Living.

2.3.1.7 Provide ongoing technical support for billing and reporting requirements.

2.3.1.8 Encourage providers to apply for IPP funding to facilitate network expansion and capacity building.

~~2.3~~2.3.1.9 Through IPP funds, AAH as partnered with UCSF's THE Collective (Alameda County Training Development Unit) to provide ongoing soft skills development and additional training for providers.

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~~2.3.1.1~~2.3.2.1 AAH Analytics team produces monthly eligibility lists based on defined criteria for each population of focus.

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2.3.2.2 AAH Analytics team distributes eligibility lists across the network of ECM Providers

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2.3.2.3 AAH also reviews referrals coming in from other AAH departments, ECM Providers, providers, ~~and~~ members, and other entities serving adults living in the community who are at risk of Long-Term Care institutionalization and nursing facility residents transitioning to the community. ~~.~~ Members may self-refer into ECM and/or dis-enroll at any time. AAH has a no wrong door policy. AAH will accept an ECM referral from PCPs, clinics, community & county mental health providers, community-based organizations, hospitals, skilled nursing facilities, acute rehabilitation centers, CCS, foster care offices, Regional Centers, First 5 County Commissions and centers, and local perinatal programs.

2.3.2.4 AAH uses a closed loop referral system for all ECM referrals. This includes, but is not limited to, tracking where the referral was sent from, which population of focus the member is eligible for, which population of focus the member is authorized for (if different from initial referral request), which ECM provider will be assigned to this member and confirmation that ECM services have started.

2.3.2.4.1 For Children/Youth and Pregnant/Postpartum populations of focus, a regular report is generated to monitor these vulnerable populations.

2.3.2.4.2 Monitoring the referral report will improve communication between AAH and ECM providers to ensure members are being served appropriately.

~~2.3.1.3~~

~~2.3.1.4 Delegated ECM Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.~~

~~2.3.2~~2.3.3 Contracts with ECM Providers for provision of ECM services and ensures ECM Providers fulfill required duties and achieve ECM goals (See CM-013 ECM Oversight, Monitoring and Controls).

~~2.3.3~~2.3.4 Notifies ECM Providers of inpatient admissions and ED visits through the following mechanisms:

~~2.3.3.1~~2.3.4.1 Daily census reports distributed by the AAH Analytics team; includes the admission and discharge status.

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ECM	Enhanced Care Management
AAH	Alameda Alliance for Health
CM	Case Management
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AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Provider Relations
Analytics

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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
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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 02/21/2023, 9/19/2023

REFERENCES

~~California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021~~
ECM Policy Guide (ca.gov)

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MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

POLICY AND PROCEDURE

Policy Number	CM-009
Policy Name	Enhanced Care Management Program Infrastructure
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
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AFFECTED DEPARTMENTS/PARTIES

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Provider Relations
Analytics

RELATED POLICIES AND PROCEDURES

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
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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, 01/20/2022, 03/22/2022, 6/20/2022, 02/21/2023, 9/19/2023

REFERENCES

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MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

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	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	8/17/2005
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	TBD

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.

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

2.1 Member Identification: AAH identifies eligible members through the following mechanisms:

2.1.1 AAH generates a list of ECM eligible members on a monthly basis.

2.1.1.1 AAH verifies AAH Member eligibility and excludes disenrolled Members.

2.1.1.2 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 data from TruCare (AAH care management system)
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

2.1.1.3 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).

2.1.1.4 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.

2.1.1.5 Any exclusion and/or non-duplication criteria as outlined in the DHCS ECM Program Guide will be incorporated into the identification logic, when applicable, and pending data source availability.

2.1.2 AAH applies tiering logic to the final AAH ECM eligibility list and assignment 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 not currently contracted to provide ECM. Should CCS Providers join the ECM Provider network, AAH will assign 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.

2.1.3 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.

2.1.4 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.

2.1.4.1 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 ECM.

2.1.4.2 For subcontracted entities (delegates), the same process for referring/requesting ECM authorization applies as directed above.

2.1.5 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.

2.1.5.1 When AAH becomes aware of such a request, AAH will automatically authorize the Member for ECM services for 12 months.

2.1.5.2 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.

2.1.5.3 When available, AAH will review historical utilization data using a 90-day look-back period to identify Members who have received ECM.

2.1.5.4 These Members will be reassessed by the ECM Provider, prior to the end of the 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 Bundle. (See *CM-011 Enhanced Care Management & Transitions of Care Attachment A*)

2.1.5.5 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.

2.2 Risk Grouping: AAH will apply a Risk Grouping methodology as follows:

2.2.1 Initial administrative data tiering will be performed on the entire ECM Universe.

2.2.1.1 Claims, encounters and supplemental data will be used to identify "high risk" members defined as meeting at least one of the following criteria:

2.2.1.1.1 Four (4) or more Emergency Department (ED) visits in a 12-month period.

2.2.1.1.2 Two (2) or more unplanned inpatient admits or Skilled Nursing Facility (SNF) stays in a 12-month period.

2.2.1.1.3 Members meeting the homeless Population of Focus

2.2.1.1.4 Members meeting the Serious Mental Illness (SMI) and/or the Substance Use Disorder (SUD) Population of Focus.

2.2.1.2 The ECM eligible members identified through this process will fall into the High Tier.

2.2.1.3 High Tier members will be paid at a rate and payment structure that takes into consideration the increased ECM services experienced by the High Tier members. ECM Providers enrolling High Tier members will be required to have weekly encounters and at least one in-person encounter a month to be eligible for the enhanced rate. 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.

2.2.1.4 The tiering logic for High Tier will be assessed by AAH for validity no less than annually and modified as needed.

2.2.1.5 All other ECM eligible members will fall into the Low Tier.

2.2.1.6 ECM Providers enrolling Low Tier members will be required to have monthly encounters.

2.2.2 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.

2.2.3 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.

2.2.3.1 All members within a Tier will be paid at the same rate.

2.2.3.2 The tiering logic for the Low Tier will be assessed by AAH for validity at least annually and modified and as needed.

2.3 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
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

CM-010 Enhanced Care Management – Member Identification and Grouping

HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 03/22/2022, 05/23/22, 06/20/2022
02/03/2023, 02/08/2023, 9/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

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	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	8/17/2005
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	~~9/19/2023~~TBD

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.

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

2.1 Member Identification: AAH identifies eligible members through the following mechanisms:

2.1.1 AAH generates a list of ECM eligible members on a monthly basis.

2.1.1.1 AAH verifies AAH Member eligibility and excludes disenrolled Members.

2.1.1.2 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 M~~m~~anagement (CM) assessment and Utilization Management (UM) review data from TruCare (AAH care management system)
Information about S~~s~~ocial D~~d~~eterminants of H~~h~~ealth, including standardized assessment tools including Protocols for Responding to and Assessing Patients' Assets, Risks and Experiences ~~(e.g.~~ PRAPARE) and~~/or~~ 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 ~~(e.g.~~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 ~~children in County Organized Health System (COHS) counties~~ 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~~Not available~~
School absentee or truancy information	When available

2.1.1.3 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).

2.1.1.4 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.

2.1.1.5 Any exclusion and/or non-duplication criteria as outlined in the DHCS ECM Program Guide will be incorporated into the

identification logic, when applicable, and pending data source availability.

2.1.2 AAH applies tiering logic to the final AAH ECM eligibility list and assignment 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 not currently contracted to provide ECM. Should CCS Providers join the ECM Provider network, AAH will assign 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.

2.1.3 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.

2.1.4 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.

2.1.4.1 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 ECM.

~~2.1.4.1~~2.1.4.2 For subcontracted entities (delegates), the same process for referring/requesting ECM authorization applies as directed above.

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2.1.5 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.

2.1.5.1 When AAH becomes aware of such a request, AAH will automatically authorize the Member for ECM services for 12 months.

2.1.5.2 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.

2.1.5.3 When available, AAH will review historical utilization data using a 90-day look-back period to identify Members who have received ECM.

2.1.5.4 These Members will be reassessed by the ECM Provider, prior to the end of the 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 Bundle. (See *CM-011 Enhanced Care Management & Transitions of Care Attachment A*)

~~2.1.5.4~~2.1.5.5 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.

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2.2 Risk Grouping: AAH will apply a Risk Grouping methodology as follows:

2.2.1 Initial administrative data tiering will be performed on the entire ECM Universe.

2.2.1.1 Claims, encounters and supplemental data will be used to identify "high risk" members defined as meeting at least one of the following criteria:

2.2.1.1.1 Four (4)~~-~~ or more Emergency Department (ED) visits in a 12-month period.

2.2.1.1.2 Two (2) or more unplanned inpatient admits or Skilled Nursing Facility (SNF) stays in a 12-month period.

2.2.1.1.3 Members meeting the homeless P~~p~~opulation of F~~f~~ocus

2.2.1.1.4 Members meeting the Serious Mental Illness (SMI) and/or the Substance Use Disorder (SUD) P~~p~~opulation of ~~f~~Focus.

2.2.1.2 The ECM eligible members identified through this process will fall into the High Tier.

2.2.1.3 High Tier members will be paid at a rate and payment structure that takes into consideration the increased ECM services experienced by the High Tier members. ECM Providers enrolling High Tier members will be required to have weekly encounters and at least one in-person encounter a month to be eligible for the enhanced rate. 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.

2.2.1.4 The tiering logic for High Tier will be assessed by AAH for validity no less than annually and modified as needed.

2.2.1.5 All other ECM eligible members will fall into the Low Tier.

2.2.1.6 ECM Providers enrolling Low Tier members will be required to have monthly encounters.

2.2.2 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.

2.2.3 Those members with the highest tier ~~RUB scores~~ will be placed higher on the priority list within the respective Tiers and ECM Providers will be asked to prioritize outreach to those members.

2.2.3.1 ~~Regardless of RUB score,~~ Aall members within a Tier will be paid at the same rate.

2.2.3.2 The tiering logic for the Low Tier will be assessed by AAH for validity at least annually and modified and as needed.

2.3 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

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Health Care Services
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CM-011 Enhanced Care Management – Care Management & Transitions of Care
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CM-014 Enhanced Care Management – Operations Non-Duplication
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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

N/A

REVISION HISTORY

05/20/2021, 03/22/2022, 05/23/22, 06/20/2022
02/03/2023, 02/08/2023~~6/28/2022~~, 9/19/2023

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REFERENCES

ECM Policy Guide (ca.gov)

~~California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021~~

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-011
Policy Name	Enhanced Care Management – Care Management & Transitions of Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	02/01/2000
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Outreach and engagement are ensured and Enhanced Care Management (ECM) services are prioritized according to risk grouping tiers by ECM Providers. ECM Members are thoroughly assessed, including complex medical conditions, behavioral conditions and/or social needs. Health Action Plans (HAPs) are developed to assist in the management of the Member's needs including housing (instability, homelessness), Transition of Care support and Referral tracking and follow-up. Improving Quality of Care, patient safety and prevention of unnecessary hospital or emergency department admissions/visits are a key focus.

PROCEDURE

1.0 Pre-enrollment Member Outreach and Engagement

1.1 Each ECM Provider is responsible for developing and implementing outreach and engagement strategies for the purpose of enrolling Members into ECM. Outreach and engagement efforts are made according to Members' tiering level, where High Tier Members have priority, followed by Low Tier Members.

1.2 ECM Providers routinely obtain and review information about newly eligible Members. If the ECM Provider is not the ECM Member's Primary Care Provider (PCP), the ECM Provider reaches out to confirm the ECM Member's PCP and informs the PCP of the Member's assignment to the ECM Provider. The ECM Provider coordinates care with the PCP and assigns an appropriate team member (Lead Care Manager) who is responsible to develop and implement an outreach and engagement plan for each eligible ECM Member. Lead Care Managers who serve adults living in the community who are risk of Long Term Care (LTC) institutionalization

and nursing facility residents transitioning to the community will be trained on person-centered planning, as required by federal law (Per 42 CFR § 438.208 the care plan must be developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR § 441.301(c)(1) and (2)) for members with long-term services and supports (LTSS) needs. If the ECM Member contacts the ECM Provider or AAH to requests a change of Lead Care Manager, AAH will work with the ECM Provider to re-assign the ECM Member to another Lead Care Manager. ECM Providers will have a defined process, approved by AAH, for assigning and changing a Lead Care Manager. This process is the same for subcontracted plans (delegates).

1.2.1 Care team assignments for conducting outreach and enrollment should be customized for the Member, taking into consideration a Member's health needs, conditions, culture, language, location and other characteristics, as appropriate.

1.2.2 Individuals assigned to conduct outreach and engagement for enrollment and ongoing engagement may include, but are not limited to, community health workers and care coordinators.

1.2.3 Engagement plans are individualized using various approved strategies most appropriate for each Member, including provisions for Members experiencing homelessness.

1.2.4 Outreach and engagement plans take into account any background information available from care records, claims, or other providers regarding physical and behavioral health conditions, history of trauma, Member's language and cultural preferences, health literacy, preferred modes of communication (e.g., phone versus text), housing and work history, current housing status other social factors that may have historically been barriers to locating and contacting the Member, and any patterns of behaviors relevant to when/where/how the Member has sought care in the past.

1.2.5 Active outreach strategies may include but not be limited to:

1.2.5.1 Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts;

1.2.5.2 With member permission, direct communications with Members by letter, email, texts, telephone;

1.2.5.3 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

1.2.5.4 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.

1.2.6 Outeach efforts for high priority members will progress over ninety (90) days from the ECM Provider's receipt of the attributed ECM Member list. Outreach efforts will consist of:

1.2.6.1 Assigned Members in the High Tier will receive a minimum of every other week outreach contacts/attempts.

1.2.6.2 Assigned Members in the Low Tier will receive a minimum of monthly outreach contacts/attempts.

1.2.7 All attempts to contact will be documented within the ECM Provider's care management platform or equivalent platform.

1.2.7.1 During initial contact by an ECM Provider care team member conducting outreach, each Member is fully informed about ECM and terms of their participation, in accordance with this policy, and

asked to either consent or decline to participate in ECM. A successful outreach contact shall consist of the following:

1.2.7.1.1 Confirm Member eligibility for ECM.

1.2.7.1.2 Verify if Member is receiving any care management/coordination services with any other program.

1.2.7.1.2.1 If the Member self-reports in the negative, they can be enrolled in ECM.

1.2.7.1.2.2 If the Member confirms enrollment in another program, they will be advised to choose only one of the programs.

1.2.7.1.3 As Members are reassessed, the ECM Provider team will again verify that the Member is not enrolled in duplicate care management/care coordination services or programs.

1.2.7.2 Document the Member's verbal or written consent in the care management record.

1.2.7.3 Notify and coordinate care with the Member's PCP and relevant specialty providers of Member's enrollment in ECM.

1.2.7.4 Either initiate or plan to complete the HAP with Member.

1.2.7.5 If the Member declines to participate in ECM:

1.2.7.5.1 Member is informed regarding continuing care with their PCP and obtaining assistance with coordination, as appropriate.

1.2.7.5.2 Member is informed that they may re-engage and receive ECM services at any time in the future as long as he or she continues to meet ECM eligibility requirements.

1.2.7.5.3 Declination is documented in the ECM Provider's care management platform or system of record.

1.2.7.6 AAH monitors, documents, and reports the progress and results of all ECM activities required to be reported to the Department of Health Care Services (DHCS), in accordance with provisions of this policy and any DHCS Program Guide.

2.0 Health Action Plan

2.1 The Health Action Plan (HAP) is a combination of the ECM Assessment and the resultant Care Plan. The combination is known as the HAP (See Related Workflow Documents or Other Attachments).

2.2 ECM Assessment

2.2.1 The ECM Assessment is administered to provide a deeper base of knowledge needed to address complex medical conditions, longer-standing psychosocial or health care needs and gaps. Assessment information will include, but is not limited to:

2.2.1.1 Physical health;

2.2.1.2 Mental health;

2.2.1.3 Substance Use Disorder (SUD);

2.2.1.4 Community-based Services;

2.2.1.5 Palliative care;

2.2.1.6 Trauma-informed care needs;

2.2.1.7 Social Supports;
2.2.1.8 Housing and other Social Determinants of Health; and
2.2.1.9 Utilization

2.2.2 Addressing palliative care and trauma informed care needs

2.2.2.1 The ECM Assessment addresses the following palliative care domains: pain; difficulty taking medications; physical function; social connections; and advance (directive) planning. The Alliance incorporates the elements of palliative care into the ECM Assessment without using the word "palliative."

2.2.2.2 The ECM Assessment addresses the following trauma-informed care domains: safety, mental health, substance use disorder, pain, utilization, and disease burden. The Alliance incorporates the components of trauma-informed care into the ECM Assessment without using the word, "trauma" and uses open-ended questions designed to elicit responses that could include experiences considered to be traumatic.

2.2.2.3 Recognizing that palliative care and trauma-informed-care may be new skill sets for ECM Provider staff, trainings to address and improve palliative care and trauma-informed care assessments will be regularly offered to ECM Providers.

2.2.3 ECM Providers make multiple efforts to contact newly enrolled ECM Members to conduct the ECM Assessment which will be repeated yearly and with any transition in care or other major event.

2.2.4 Following Member consent to enroll, Members identified as higher risk will be prioritized for the outreach and engagement to conduct and complete the ECM Assessment.

2.2.5 For the High Tier priority engagement group, ongoing attempts to contact occurs weekly using multiple modalities such as phone, email, and text (per the Member's documented preference) and at varying times of day and evening, for up to ninety (90) days.

2.2.6 For the Low Tier group, ongoing attempts to contact occurs monthly using multiple modalities and times of day and evening, for up to ninety (90) days.

2.2.7 If unable to contact the Member by phone or mail, every avenue is researched to secure a valid phone number (e.g. the PCP office, specialty care provider office, a vendor where durable medical equipment is rented from, current pharmacy used, or data available on other data exchange platforms, etc.).

2.2.8 The ECM Provider will document all contact attempts in their care management platform or system of record.

2.2.9 To facilitate communication among the Member's health care Providers, the completed ECM Assessment is made available to the entire ECM Provider team and the Member's PCP.

2.2.10 AAH ECM Providers will track, trend, monitor, and report ECM Assessment administration and reassessment practices for all eligible members.

2.3 Care Plan

2.3.1 Once the ECM Assessment is completed, the designated ECM Provider team member develops the Care Plan for each Member enrolled in ECM

services in collaboration with the Member, caregiver, and other members of the ECM Provider team.

2.3.2 The designated ECM Provider team member works with the Member to develop and prioritize goals according to the Member's priorities and preferences. Individualized goals will have timeframes and strategies for addressing each goal. Members have the opportunity to be involved in the development, review, and approval of the Care Plan and any amendments to the Care Plan, as appropriate.

2.3.3 The Care Plan is developed using the ECM Assessment data as well as other information available from various sources such as utilization data, pharmacy data, or notes from any AAH Care Management (CM) activities.

2.3.4 The Care Plan will include, but is not limited to, the following elements, as appropriate:

- 2.3.4.1 Language and communication preferences;
- 2.3.4.2 Risk level or complexity tier;
- 2.3.4.3 Housing status;
- 2.3.4.4 Care team supports, including contact information;
- 2.3.4.5 Emergency Department (ED)/hospital utilization;
- 2.3.4.6 Medications and dosage;
- 2.3.4.7 Any care needs identified on the ECM Assessment pertaining to chronic physical condition, behavioral health status including cognitive functions, developmental health and dementia, trauma-informed care, palliative care needs, and specific goals and action plan;
- 2.3.4.8 Self-management goals, including barriers to success, interventions, and goal status;
- 2.3.4.9 Timeframes for reassessment and ECM Provider follow-up frequency;
- 2.3.4.10 Coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies such as In-Home Supportive Services (IHSS) and Community-Based Adult Services (CBAS);
- 2.3.4.11 Care coordination and social support needs such as arranging transportation, obtaining appointments, referral tracking and status updates (including housing referrals), coordinating interpreter services, and educating on the importance of preventative services.

2.3.5 The HAP is accessible to all members of the care team:

- 2.3.5.1 The Member will be provided, upon request, a copy of the HAP by mail or in person and updates provided during each follow up.
- 2.3.5.2 The PCP will be given the Member's HAP.
- 2.3.5.3 Other ECM Provider care team members have access to the HAP and have the ability to update and modify the HAP.

2.3.6 Quarterly, or more frequently if needed, the ECM Provider reviews the HAP with each Member and will reassess and update it with any changes in the Member's progress, status or health care needs and/or according to the HAP follow up plan. A clinician at the ECM Provider reviews the HAP. AAH clinician ensures that appropriate ECM clinician has provided oversight to ensure the HAP is maintained and updated as appropriate

through quarterly audits.

2.3.6.1 A care team member reviews utilization reports identifying a Member who has had a recent hospital admission, discharge or ED visit. This will alert them to contact the Member, as appropriate, to review the current HAP and make changes as necessary.

2.3.6.2 The ECM Provider team member reviews the HAP with the Member at each contact to assess the progress made towards the goals identified in the HAP as well as tracks referrals made and follow-up on completion and communication on each referral.

2.3.6.3 The ECM Provider will make updates to the HAP if a goal has changed priority, has been met, or is no longer applicable.

2.3.6.4 The HAP will be completed within ninety (90) days of ECM enrollment.

3.0 Member Ongoing Engagement and Care Management Services

3.1 ECM Provider team members provide ongoing care management support in person and telephonically at a frequency determined by the Member's complexity (Tier level) and desired level of involvement in ECM.

3.2 The ECM Lead Care Manager serves as the primary point of contact and supports activities provided by ECM Providers which include, but are not limited to:

3.2.1 Assessing and managing Members using evidence-based clinical protocols and resources;

3.2.2 Ensuring completion of HAP within specified timeframe;

3.2.3 Documenting Member's choice of caregiver or family/support persons and assisting Members and chosen family/support persons with access to appropriate resources;

3.2.4 Assisting Members and chosen family/support persons with scheduling appointments;

3.2.5 Tracking and monitoring internal and external referrals;

3.2.6 Developing and communicating self-management plans with input from the Member and caregiver(s)/family, as well as helping the member to identify and build on successes and potential family and/or support networks;

3.2.7 Providing appropriate, timely, and actionable Member education to improve self-management skills;

3.2.8 Empowering Members to enhance self-management using Motivational Interviewing techniques;

3.2.9 Using problem-based, comprehensive case planning, with measurable, prioritized goals and interventions tailored to the complexity level of the Member as determined by the initial and ongoing assessments;

3.2.10 Providing care management that is Member-centric and culturally aware;

3.2.11 Interacting with Members and family and / or support persons from a holistic perspective, promoting collaboration and coordination, through all levels of the health care continuum including physical and behavioral health programs, pharmaceutical management, and community-based programs;

3.2.12 Monitoring and supporting treatment adherence (including medication management and reconciliation);

3.2.13 Assisting in attainment of the Member's goals as described in the HAP;

3.2.14 Encouraging the Member's decision-making and continued participation in ECM; and

3.2.15 Accompanying Members to appointments, as needed.

3.3 AAH ensures that the ECM Member's acuity will be the basis for the appropriate provision of ECM services by the ECM Provider. Members in the higher acuity risk groupings (tiers) will receive more intensive ECM services at a higher frequency.

3.3.1 High Risk (High Tier)

3.3.1.1 Attempt weekly contacts with the Member and, at a minimum, one in-person meeting per month. The in-person meeting per month may be temporarily suspended during a declared public health emergency; however, alternative means of communication with the Member should be employed to contact the Member during this time including secure teleconferencing and telehealth visits;

3.3.1.2 On-going communication with PCP regarding HAP updates and information-sharing;

3.3.1.3 Weekly, systematic case reviews by the ECM Provider team (including PCP when needed) for measurement-based care to review the Member's HAP, their progress towards goals, adherence to treatment plan, and make necessary changes in treatment and strategy to engage the Member in their Care Plan; and

3.3.1.4 Documentation of each contact and updates to the HAP will be made in the care management platform or system of record.

3.3.2 Low/Medium Risk (Low Tier)

3.3.2.1 Attempt monthly contacts with the Member;

3.3.2.2 ECM Provider staff can utilize a combination of telephonic and face-to-face encounters, based on the Member's preference, and as documented in the HAP. In-person meeting may be temporarily suspended during a declared public health emergency; however, alternative means of communication with member should be employed to contact member during this time including secure teleconferencing and telehealth visits.

3.3.2.3 On-going communication with PCP regarding HAP updates and information sharing;

3.3.2.4 Periodic systematic case reviews by the ECM Provider team (including PCP when needed) for measurement-based care to review the Member HAP's, their progress towards goals, adherence to treatment plan, and make necessary changes in treatment and strategy to engage the Member in their care plan; and

3.3.2.5 Documentation of each contact and updates to the HAP will be made in the care management platform or system of record.

4.0 Housing

4.1 ECM Members in need of housing services may be identified as follows:

4.1.1 ECM Providers conduct an ECM Assessment upon enrollment, annually, and with any change in status. The ECM Assessment includes questions that identify Members' homelessness or housing instability concerns.

4.1.2 Care team may be alerted to Members' housing concerns through the regular course of providing comprehensive care management services.

4.2 Members experiencing homelessness or housing instability will include goals

related to housing on their HAP. Goals may address:

4.2.1 Housing navigation;
4.2.2 Transitional support;
4.2.3 Tenancy support;
4.2.4 Assistance in finding permanent housing.
4.2.4.1 Referrals to housing navigation is a component of the ECM Provider care coordinator's functions.

4.3 AAH will provide the following support to ECM Providers:
4.3.1 Cultivate relationships with local housing agencies including permanent housing providers;
4.3.2 Cultivate relationships with homeless service providers;
4.3.3 Provide advocacy for Members through housing agencies and coalitions; and
4.3.4 Partner with Alameda County Health Care Services Agency (HCSA) and Corporation for Supportive Housing to create and provide educational offerings and technical assistance around housing navigation and tenancy supports, as needed.

5.0 Referral Management

5.1 Referral management is a component of the ECM Provider care coordinator's primary responsibilities. The ECM Provider care coordinator will track, monitor and provide referral coordination for all new, pending or completed referrals captured within the web-based care management platform or equivalent platform.
5.1.1 The ECM Assessment is the opportunity to gather and document relevant information regarding a member's needs, including medical health, behavioral health, palliative care, and social needs.
5.1.2 A member-centered plan of care is generated from the ECM Assessment which includes referrals agreed to by the ECM Member. These referrals may link ECM Members to medical specialty care, primary care, behavioral health, long term care services, palliative care, housing, community supports and any community resources which address the Member's needs.
5.1.3 Referrals may be placed to various services and appropriate community agencies via fax, telephone, in person or through secure electronic methods.
5.1.4 ECM Providers ensure that referrals were received and processed by the receiving agencies or providers, track whether services were received by the ECM Member and document the outcomes of the referrals.
5.1.5 Referrals will be followed up by phone, fax, in person or via secure electronic pathways, at scheduled intervals, to ensure that a referral has been completed and the ECM Member appropriately linked to services.

5.2 Referral and transition coordination include the following activities:
5.2.1 Provide system navigation and serve as the point of contact for ECM Members and families for questions or concerns related to internal or external referrals;
5.2.2 Review details and expectations about the referral with the Member and/or caregivers;
5.2.3 Gather and send necessary medical information such as clinical background, diagnosis, prognosis, and referral needs, as appropriate, to referral source(s);

5.2.4 Assist Members in problem-solving potential barriers (e.g., request interpreters as appropriate, transportation assistance or community resource assistance);
5.2.5 Ensure that referrals are addressed in a timely manner, as specified by the ordering Provider;
5.2.6 Remind patients of scheduled appointments based on the Member's preference and as documented in the HAP;
5.2.7 Monitor referral activity daily, providing additional assistance to Members who have not completed referrals within specified timeframe, have cancelations, missed appointments, or other reasons for an incomplete referral;
5.2.8 Maintain ongoing tracking and appropriate documentation of referrals to promote care team communication and continuity of care; and
5.2.9 Ensure the Member's health record is up to date with information on specialist consults, hospital summaries, diagnostic results, ED visits and community organization information related to the health of the Member.

6.0 Transitions of Care
6.1 AAH collaborates with ECM Provider staff to coordinate care across all healthcare settings, providers, and services to assure continuity of care.
6.2 ECM Providers, in partnership with AAH, continuously work with all facilities to ensure that Members are receiving comprehensive quality care in the least restrictive setting.
6.3 AAH ensures that ECM Providers have access to daily hospital admission, discharge and ED visit information for ECMMembers.
6.4 Member engagement and Transition of Care (TOC) activities begin during ED visit or hospital admission, when possible.
6.4.1 Upon notification of an ED visit or inpatient hospital admission, the ECM Provider care coordinator begins transition activities for ECM Members. Activities include, but are not limited to:
6.4.1.1 Engaging with the Member during their ED visit or hospitalization, if possible;
6.4.1.2 Engaging with the Member within 48 hours of their ED visit or hospital discharge;
6.4.1.3 Reviewing discharge plan and medication changes;
6.4.1.4 Updating HAP;
6.4.1.5 Referral management and coordination support; and
6.4.1.6 Scheduling timely follow-up appointment(s) with the Member's PCP and specialists, as appropriate.
6.4.1.6.1 Includes arranging transportation for transition care and to medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policies and procedures.
6.4.1.7 Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services.
6.4.1.7.1 When possible, provide transition support to permanent housing.
6.4.1.8 The ECM Provider team contacts the Member to monitor their status before, during and after a transition of care, when possible.
6.4.2 The ECM Provider care coordinator will update the ECM Provider team, or

the multidisciplinary care team, who will assist with the coordination and delivery of services or schedule case conferences to discuss supportive measures needed, changes to the HAP, and discussions to prevent future utilization.

6.4.3 ECM Providers have ongoing communication with facilities to monitor Members' needs and the services provided to them.

6.4.3.1 AAH prevents readmissions by utilizing evidence-based best practices for Transitions of Care and encouraging ECM Providers to follow the same. AAH tracks readmissions via an ECM-specific dashboard that is shared with ECM Providers on a regular basis.

7.0 Member Transition to Lower Level of Care/Disenrollment

7.1 ECM Provider teams will continue to reassess the Member's risk status level and programmatic appropriateness.

7.1.1 Members transitioning to ECM from the Health Homes Program (HHP) or Whole Person Care (WPC) Pilot will be reassessed within a period of six (6) months to determine the most appropriate level of services for each Member, whether in ECM or a lower level of care coordination.

7.1.2 When Members have experienced a 6-month period of stability, defined by well managed clinical measures, no hospital or ED utilization and have successfully met their self-management goals on the HAP, they are ready to transition to a lower level of care and disenroll or "graduates" from ECM.

7.1.3 If a Member consented and engaged in ECM but has had no active participation for ninety (90) days, despite ongoing outreach and engagement efforts by the ECM Provider team, the Member will be disenrolled.

7.1.4 If a Member chooses to disenroll for any reason, the Member will be disenrolled.

7.1.5 If a Member is now participating in another program excluding them from ECM eligibility, the Member may choose the alternate program and be disenrolled from ECM.

7.1.6 The disenrollment reason will be documented in the web-based care management platform or equivalent platform.

7.1.7 The ECM provider will notify AAH when the member is ready to transition to a lower level of care. The ECM Provider will use the Alliance Enhanced Care Management Graduation Bundle (Attachment A) to determine when an ECM Member is ready for graduation and ready to transition to a lower level of care. AAH will not be determining the member's readiness for graduation but will follow the recommendation of the ECM Provider who is providing the direct services. AAH will follow the standard Grievance & Appeals process when a member disputes ECM graduation and transition to a lower level of care.

7.1.8 The provider will provide a warm handoff, when appropriate, to the receiving lower level Care Management provider. Lower level Care Management may include programs at the ECM Provider, or other community Care Management entities, including AAH telephonic Care Management. If the ECM Provider has difficulty locating an appropriate lower level of care provider, the Alliance will assist in identifying an appropriate provider, including acceptance of the member into the AAH

telephonic care management program. AAH will work with ECM Provider to graduate the member and transition to a lower level of care when needed.

7.2 The process ECM Providers are expected to use to notify the Alliance when discontinuation criteria are met is through the monthly submission of the DHCS Member Information File. This file includes Disenrollment Reason codes notifying the Plan of discontinuation of delivery (e.g. graduation, disenrollment, unwilling to engage, provider unable to connect after multiple attempts).Upon notification from the ECM Provider, AAH will issue a Notice of Action (NOA) to Members disenrolled from ECM for specific situations. AAH will send the NOA to the Member, ECM provider and PCP within thirty (30) days after the effective date of ECM disenrollment. AAH will send a NOA to the Member, the ECM Provider, and the Member's PCP (if the ECM Provider is not the Member's PCP) if:

- 7.2.1 The Member develops a change in eligibility such as an exclusionary condition;
- 7.2.2 The Member's eligible chronic condition(s) become well-managed (for six consecutive months);
- 7.2.3 The Member has met all care plan goals;
- 7.2.4 The Member is ready to transition to a lower level of care;
- 7.2.5 The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or
- 7.2.6 A Member consents and enrolls, but there is no documented active participation for ninety (90) days despite outreach and engagement efforts as part of care management.
- 7.2.7 When ECM services are discontinued; the Member or the ECM Provider may request the member be transitioned to a lower level of care management. AAH will work with the ECM Provider to complete a warm handoff to AAH's telephonic Case Management or to a community-based case management program.

7.3 AAH will not send a NOA to a member who chooses to disenroll from ECM.

DEFINITIONS / ACRONYMS

AAH	Alameda Alliance for Health
NOA	Notice of Action
ECM	Enhanced Care Management
HAP	Health Action Plan
TOC	Transition of Care
WPC	Whole Person Care

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
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
UM-016 Transportation Guidelines

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alameda Alliance for Health: ECM Program
ECM Provider ECM Assessment

Staff Person Completing Form:
Date Form Completed:

Demographics

Name:_____

DOB: _____ AAH#:_____ CIN:_____

Type of Assessment: ☐ New ☐ Annual

Race/Ethnicity: ☐ African American/Black ☐ Latino/Hispanic
☐ Asian/Pacific Islander ☐ Native American
☐ Black/Non-Hispanic ☐ White/Non-Hispanic
☐ More than one race/ethnicity
☐ Other: _____

Gender: ☐ Male ☐ Female ☐ Transgender (F->M M->F) ____ ☐ Non-binary ☐ Other _____

Any cultural/religious preferences related to member's healthcare? ☐ Yes ☐ No

Preferred language:_____

*Is anything going on with your health right now that is causing you a lot of stress?
☐ Yes ☐ No

Describe:

How would you describe your overall health?
☐ Excellent
☐ Very Good
☐ Good
☐ Fair
☐ Poor

Physical Environment

***Type of Residence:**
☐ Apartment
☐ House
☐ Assisted Living
☐ SRO (Permanent? Supported?)
☐ SNF
☐ Literally Homeless: If yes, please circle one of the following: car shelter encampment outside solo
☐ Temporary housing - alone
☐ Temporary housing-with friends and/or family
☐ Other:_____

If homeless, when was the last time you were stably housed?
_____

***Transportation:**
Do you have access to transportation?
☐ Yes ☐ No

If no, please describe your ability to access transportation:

***Safety:**
Do you feel safe in your home?
☐ Yes ☐ No

If no, what if anything would help right now?

Current Housing Programs:
☐ Section 8
☐ Housing Authority
☐ None
☐ Unknown
☐ Other: _____

Living Arrangement:
☐ Lives alone
☐ Lives with family/friends
☐ Lives with pet (indicate if certified service animal.

Financial Resources (optional):
Household Income per month (includes income of client and other household members)

Client Income Source:

Employment? Yes ☐ No ☐ Amount ___

SSD Yes ☐ No ☐ Amount ___

SSI Yes ☐ No ☐ Amount ___

Food Stamps Yes ☐ No ☐ Amount ___

TANF Yes ☐ No ☐ Amount ___

Unemployment Yes ☐ No ☐ Amount ___

VA Benefits Yes ☐ No ☐ Amount ___

Gen. Assistance Yes ☐ No ☐ Amount ___

Other Yes ☐ No ☐ Amount ___

Total _____

No Resources (circle if applicable)

Clinical Information

Physical Health Diagnoses (focus on chronic conditions):
_____

Mental Health Diagnoses: _____

Primary Care Physician: _____
Phone Number: _____
Specialty Physician(s): _____
Phone Number: _____
Name of pharmacy/service and contact number (if applicable): _____

Medical Facility most often used (ED/Hospital): _____

*How well do you understand your diagnoses and/or prescriptions? ☐ Not well ☐ Well enough ☐ Very well

*Do you have trouble getting appointments with your primary health care provider? ☐ Yes ☐ No

When was your last visit to Primary Care Provider? _____

When is your next visit to Primary Care Provider? _____

*Do you receive dental care? ☐ Yes ☐ No
If yes name of dentist: _____ Phone number: _____

*Do you have pain when eating? ☐Yes ☐ No

	Yes	No	Details
In last 12 months, have you been to the ER or been hospitalized?	☐	☐	
Have you ever been hospitalized for mental health?	☐	☐	
Have you followed up with doctor since hospitalization?	☐	☐	
	Yes	**No**	**Details**
In last 12 months, have you had any surgeries?	☐	☐	
Have you followed up with doctor since surgery?	☐	☐	

Medications

Do you have any prescription or over-the-counter medications? ☐ Yes ☐ No

Name of medication:	Dose (ex. 5 mg)	Route (by mouth, subcutaneous)	Frequency (daily, weekly, as needed, etc)	Diagnosis	Date filled / expired

*Is there anything that makes it hard to take your medications as prescribed?
Some options below for you and patient to check off. "Do you ever…"

☐ Forget to take medications ☐ Forget to refill prescriptions on time ☐ Doubt the value of your medications ☐ Have problems reading the labels, because they're in the wrong language ☐ Have trouble reading the labels because you can't see well ☐ Have medication side effects	☐ Have difficulty opening pill bottles ☐ Get concerned about drug safety ☐ Get confused about medicines ☐ Have trouble getting to the pharmacy to pick up your medicines ☐ Have trouble affording your medicines ☐ Other: _____

Do you take any herbal remedies? ☐ Yes ☐ No

List any here:

Allergies		**Description**
Seasonal/ Environmental allergies	☐	
Allergies to medications	☐	
Food allergies	☐	

Pain

*Do you have chronic pain? ☐ Yes ☐ No

Details (Include things like location, cause, triggers):

What is the impact of the pain on your daily functioning? ("can you get through your day without interruption or does the pain keep you from doing certain things?")

	0= no pain	1= mild pain	2= moderate pain	3= severe pain	4= very severe pain	5= worst Possible pain
On a pain scale of 0-5 what number would you give your pain right now?	☐	☐	☐	☐	☐	☐
What number would you give your pain	☐	☐	☐	☐	☐	☐

when it is the worst that it gets?						
What number would you give your pain when it is the best that it gets?	☐	☐	☐	☐	☐	☐
At what number is the pain at an acceptable level for you?	☐	☐	☐	☐	☐	☐

Do you take medication for pain? ☐ Yes (which medicines) ☐ No	Does medication relieve the pain? ☐ All of the time ☐ Some of the time ☐ None of the time

Food Security:

*Do you have trouble accessing food?
☐ Yes☐ No

How many meals do you eat each day?
☐ 0-1☐ 2-3☐ 4-5☐ 6+

In the past 12 months have you worried that your food would run out before getting money to buy more?
☐ Yes ☐ No

In the past 12 months has your food run out because you didn't have money to get more?
☐ Yes ☐ No

Functional Assessment:

Hearing/Vision Deficits	**Yes**	**No**	
*Do you have trouble hearing?	☐	☐	Do you have hearing aids? ☐ Yes ☐ No
*Do you have trouble seeing?	☐	☐	Do you wear glasses or contacts? ☐ Yes ☐ No How is your eyesight with glasses/contacts? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Blind

Communication Barriers	**Yes**	**No**	**Notes**
Do you speak English comfortably	☐	☐	
Do you feel your speech is impaired	☐	☐	
Do you feel you have memory loss	☐	☐	
Do you feel you have trouble thinking clearly	☐	☐	

How often do you have someone help you read health care materials? ☐ Always ☐ Sometimes ☐ Never
How confident are you at filling out medical forms by yourself? ☐ Always ☐ Sometimes ☐ Never

Physical Functioning

Stairs:	**Fall Risk**
Any stairs at home? ☐ Yes ☐ No Your ability to climb one flight of stairs: ☐ No difficulty ☐ Difficulty ☐ Unable ☐ N/A – no stairs	*Have you fallen within the last 6 months? ☐ Yes ☐ No If yes, how many times?_____ Do you have fear of falling ☐ Yes ☐ No

☐ N/A – uses ramp, wheelchair, etc	Details:

Level of help needed:						
***ADLs**	**Independent**	**Supervision**	**Assistance**	**Dependent**		**Needs more help**
Bathing	☐	☐	☐	☐		☐
Toileting	☐	☐	☐	☐		☐
Dressing	☐	☐	☐	☐		☐
Walking	☐	☐	☐	☐		☐
Feeding	☐	☐	☐	☐		☐

Any home modifications needed?
☐ Yes ☐ No
Describe modifications needed:

Level of help needed:						
***IADLs**	**Independent**	**Supervision**	**Assistance**	**Dependent**		**Needs more help**
Taking Medications	☐	☐	☐	☐		☐
Hygiene (brushing teeth, brushing hair, shaving)	☐	☐	☐	☐		☐
Housekeeping/Chores	☐	☐	☐	☐		☐
Shopping/Errands	☐	☐	☐	☐		☐
Meal Preparation or Cooking	☐	☐	☐	☐		☐
Accessing Resources	☐	☐	☐	☐		☐
Managing Money	☐	☐	☐	☐		☐
Transportation	☐	☐	☐	☐		☐
Keeping track of appointments	☐	☐	☐	☐		☐
Going out to visit family or friends	☐	☐	☐	☐		☐
Using the phone	☐	☐	☐	☐		☐

*Can you live safely and move easily around in your home? ☐ Yes ☐ No

If No, does the place where you live have:

Good lighting ☐ Yes ☐ No
Good heating ☐ Yes ☐ No
Good cooling ☐ Yes ☐ No
Rails for any stairs or ramps ☐ Yes ☐ No
Hot water ☐ Yes ☐ No
Indoor toilet ☐ Yes ☐ No
A door to the outside that locks ☐ Yes ☐ No
Stairs to get into your home or stairs inside your home ☐ Yes ☐ No
Elevator ☐ Yes ☐ No
Space to use a wheelchair ☐ Yes ☐ No
Clear ways to exit your home ☐ Yes ☐ No

*Do you have family members or others willing and able to help you when you need it?
☐ Yes ☐ No

Who helps you with ADLs/IADLs?

☐ Caregiver/IHSS
☐ Family
☐ Other
☐ No one

*Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No

*Do you always have transportation available to get medical care?

☐ Always
☐ Sometimes
☐ Rarely
☐ Never

Assistive Devices:

Do you use any assistive devices such as a Cane, Walker, Tub/Shower Chair, Ramp, Commode, Raised Toilet Seat, Hospital Bed, Safety Rail, Respiratory Aids, Oxygen, or other? ☐ Yes ☐ No

Details:

*Do you have any problems or concerns with devices used? ☐ Yes ☐ No
Details:

*Do you need any additional assistive devices? ☐ Yes ☐ No
Details:

Home and Community Based Services

***IHSS (In-Home Support Services):** Receives IHSS: ☐ Yes ☐ No

Hours per month: _____ Services provided by IHSS:

☐ Name of IHSS Worker:_____

Is that worker (insert name) a:

☐ Independent Provider

☐ Family Member

☐ Other:_____

CBAS (Community-Based Adult Services):

Do you attend CBAS? ☐ Yes ☐ No

Days per week: _____

If yes, name of CBAS Center you attend:

_____

Other Home & Community Based Services:

Other services received? ☐ Yes ☐ No

List specific organizations used and services received below:

(Examples-home health, meals on wheels)

Substance Use and Behavioral Health:

Substance Use:

I have some questions about your experience with alcohol, cigarettes, marijuana, and other drugs. Some of the substances we'll talk about are prescribed by a doctor, but I will only be focusing on whether you've taken them for reasons other than prescribed or in doses other than prescribed.

In the past 6 months, how often have you used the following:	Never	Once or Twice	Monthly	Weekly	Daily	Date of last use	Is this substance a problem for you?
Alcohol • For men, 5 or more drinks • For women, 4 or more drinks							Yes ☐ No ☐
Cigarettes							Yes ☐ No ☐
Prescription Drugs for Non-Medical Reasons (circle any relevant) • Pain medicines • ADHD medicines (ex Ritalin) • Sleeping pills							Yes ☐ No ☐
Marijuana							Yes ☐ No ☐

Other drugs Cocaine, Meth, Heroin, Hallucinogens (Acid, Mushrooms, PCP, Ecstasy)							Yes ☐ No ☐

***If the client answers that he/she uses any of the above substances, and especially if he/she identifies use as a problem, ask:**
Are you willing to receive a referral to a substance use counselor? ☐ Yes ☐ No

Mental Health:

Are you receiving any psychological counseling or treatment? ☐ Yes ☐ No
Name of provider:_____
How long have you been in treatment? _____
How's it going?

_____
_____

*Are there any life crises affecting you now? ☐ Yes ☐ No
Please describe:

*Would you like to talk to someone about your feelings? ☐ Yes ☐ No
Are you interested in counseling/therapy/support group? ☐ Yes ☐ No

Have you ever received mental health or counseling services in the past? ☐ Yes ☐ No
If yes, name of provider:
Have you ever had a doctor tell you that you had a mental health condition? ☐ Yes ☐ No
If yes, what was that condition?

_____

*Have you had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No

Mood/Depression/Suicide

Over the last 2 weeks:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
How often have you been bothered by having little interest or pleasure in doing things?	☐	☐	☐	☐
How often have you been bothered by feeling down, depressed, or hopeless?	☐	☐	☐	☐
→STOP: * If the answers to one or both of the above questions are ***"More than half the days" or "Nearly every day"*** then complete the next seven questions. Otherwise, skip to the next section, "Social Resources."				
How often have you had trouble falling asleep, or sleeping too much?	☐	☐	☐	☐
How often have you been bothered by feeling tired or having little energy?	☐	☐	☐	☐

How often have you had a poor appetite or overeaten?	☐	☐	☐	☐
How often have you felt bad about yourself, or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
How often have you had trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
How often have you moved or spoken so slowly that other people have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
How often have you had thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Cognitive Function/Dementia (document patient's response)

1. What year is it? _____
2. What month is it? _____
3. Give the patient an address phrase to remember with 5 components – example: John, Smith, 42 High Street, Oakland
4. About what time is it (within one hour)? _____
5. Count backwards from 20-1. _____
6. Say the months of the year in reverse _____
7. Repeat address phrase _____

Social Resources

How often do you see or speak with family or friends?
☐ Daily ☐ Several times per week ☐ Several times per month ☐ Less than once per month ☐ Never

*Over the past month (30 days), how many days have you felt lonely?
☐Most days (I always feel lonely) ☐ More than half the days (more than 15)☐ l Less than 5 days☐ None I(I never feel lonely)

Do you participate in any social, faith-based or other community activities? ☐ Yes ☐ No
If so, please name here:

Abuse/Neglect

	Yes	No	Details
*Are you ever afraid of or intimidated by someone in your family or household?	☐	☐	
*Has someone in your family or household ever been verbally abusive or tried to control what you can or cannot do?	☐	☐	
* Are you afraid of anyone or is anyone hurting you (including someone in your household or in your family?	☐	☐	

*Is anyone using your money without your ok?	☐	☐	

Advanced Planning: I'd like to talk with you about something called advance care planning. Have you given thought to the type of medical care you would want to have or not have if you ever became too ill or injured to speak for yourself? That is the purpose of advance care planning, to ensure that you are cared for the way you would want to be, even in times when you are unable to speak for yourself. Did you know you could document your preferences ahead of time so that your care team knows about them? Would you like to talk more about how to do that?

☐ Yes☐ No

**If patient answers yes, please create a goal for the PCP or nurse/social worker on your team to talk with the patient about Advanced Directive, DPOA, and/or POLST.*

Does anyone help you make healthcare decisions or participate in your care plan?

☐ Yes☐ No

If yes, who:_____

General Health Questions
*What could you do right now to improve your health?

*What are your top 3 goals and priorities for the next 12 months?
Have you taken any steps to get to these yet?
Any asterisked (*) question on this assessment with a concerning response should be addressed in the HAP. Can be addressed either directly through goal setting, or alternatively through prompts to remind your team to follow up on the issues at a future time.

Clients Name:	Male☐ Female ☐ Other ☐	Date of Birth:
ECM Provider:	Care Coordinators Name:	Care Coordinators Phone:
PCP:	Enrollment Date:	Graduation Date:
Summary: ECM Provider long term goal for client:		
Initial HAP Screenings (if applicable)		
Screen:	Date	Score / Level
Katz ADL		
PHQ-9		
Audit - C		

SMART - **S**pecific **M**easurable **A**chievable **R**elevant **T**ime
Client's Long Term Goal(s):

Initial :		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Three Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Six Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Nine Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:

Attachment A – Alameda Alliance ECM Graduation Bundle

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 9/19/2023

REFERENCES

ECM Policy Guide (ca.gov)
42 CFR § 441.301 - Contents of request for a waiver. | CFR | US Law | LII / Legal Information Institute (cornell.edu)
APL17-013.pdf (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-011
Policy Name	Enhanced Care Management – Care Management & Transitions of Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	02/01/2000
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

Outreach and engagement are ensured and Enhanced Care Management (ECM) services are prioritized according to risk grouping tiers by ECM Providers. ECM Members are thoroughly assessed, including complex medical conditions, behavioral conditions and/or social needs. Health Action Plans (HAPs) are developed to assist in the management of the Member's needs including housing (instability, homelessness), Transition of Care support and Referral tracking and follow-up. Improving Quality of Care, patient safety and prevention of unnecessary hospital or emergency department admissions/visits are a key focus.

PROCEDURE

1.0 Pre-enrollment Member Outreach and Engagement

1.1 Each ECM Provider is responsible for developing and implementing outreach and engagement strategies for the purpose of enrolling Members into ECM. Outreach and engagement efforts are made according to Members' tiering level, where High Tier Members have priority, followed by Low Tier Members.

1.2 ECM Providers routinely obtain and review information about newly eligible Members. If the ECM Provider is not the ECM Member's Primary Care Provider (PCP), the ECM Provider reaches out to confirm the ECM Member's PCP and informs the PCP of the Member's assignment to the ECM Provider. The ECM Provider coordinates care with the PCP and assigns an appropriate team member (Lead Care Manager) who is responsible to develop and implement an outreach and engagement plan for each eligible ECM Member. Lead Care Managers who serve adults living in the community who are risk of Long Term Care (LTC) institutionalization

and nursing facility residents transitioning to the community will be trained on person-centered planning, as required by federal law (Per 42 CFR § 438.208 the care plan must be developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR § 441.301(c)(1) and (2)) for members with long-term services and supports (LTSS) needs. If the ECM Member contacts the ECM Provider or AAH to requests a change of Lead Care Manager, AAH will work with the ECM Provider to re-assign the ECM Member to another Lead Care Manager. ECM Providers will have a defined process, approved by AAH, for assigning and changing a Lead Care Manager. This process is the same for subcontracted plans (delegates).

~~1.2 ECM Providers routinely obtain and review information about newly eligible Members. If the ECM Provider is not the ECM Member's Primary Care Provider (PCP), the ECM Provider reaches out to confirm the ECM Member's PCP and informs the PCP of the Member's assignment to the ECM Provider. The ECM Provider coordinates care with the PCP and assigns an appropriate team member (Lead Care Manager) who is responsible to develop and implement an outreach and engagement plan for each eligible ECM Member. If the ECM Member contacts the ECM Provider or AAH to requests a change of Lead Care Manager, AAH will work with the ECM Provider to re-assign the ECM Member to another Lead Care Manager. ECM Providers will have a defined process, approved by AAH, for assigning and changing a Lead Care Manager.~~

1.2.1 Care team assignments for conducting outreach and enrollment should be customized for the Member, taking into consideration a Member's health needs, conditions, culture, language, location and other characteristics, as appropriate.

1.2.2 Individuals assigned to conduct outreach and engagement for enrollment and ongoing engagement may include, but are not limited to, community health workers and care coordinators.

1.2.3 Engagement plans are individualized using various approved strategies most appropriate for each Member, including provisions for Members experiencing homelessness.

1.2.4 Outreach and engagement plans take into account any background information available from care records, claims, or other providers regarding physical and behavioral health conditions, history of trauma, Member's language and cultural preferences, health literacy, preferred modes of communication (e.g., phone versus text), housing and work history, current housing status other social factors that may have historically been barriers to locating and contacting the Member, and any patterns of behaviors relevant to when/where/how the Member has sought care in the past.

1.2.5 Active outreach strategies may include but not be limited to:

1.2.5.1 Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts;

1.2.5.2 With member permission, direct communications with Members by letter, email, texts, telephone;

1.2.5.3 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

1.2.5.4 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.

1.2.6 Outreach efforts for high priority members will progress over ninety (90)

days from the ECM Provider's receipt of the attributed ECM Member list. Outreach efforts will consist of:

1.2.6.1 Assigned Members in the High Tier will receive a minimum of every other week outreach contacts/attempts.

1.2.6.2 Assigned Members in the Low Tier will receive a minimum of monthly outreach contacts/attempts.

1.2.7 All attempts to contact will be documented within the ECM Provider's care management platform or equivalent platform.

1.2.7.1 During initial contact by an ECM Provider care team member conducting outreach, each Member is fully informed about ECM and terms of their participation, in accordance with this policy, and asked to either consent or decline to participate in ECM. A successful outreach contact shall consist of the following:

1.2.7.1.1 Confirm Member eligibility for ECM.

1.2.7.1.2 Verify if Member is receiving any care management/coordination services with any other program.

1.2.7.1.2.1 If the Member self-reports in the negative, they can be enrolled in ECM.

1.2.7.1.2.2 If the Member confirms enrollment in another program, they will be advised to choose only one of the programs.

1.2.7.1.3 As Members are reassessed, the ECM Provider team will again verify that the Member is not enrolled in duplicate care management/care coordination services or programs.

1.2.7.2 Document the Member's verbal or written consent in the care management record.

1.2.7.3 Notify and coordinate care with the Member's PCP and relevant specialty providers of Member's enrollment in ECM.

1.2.7.4 Either initiate or plan to complete the HAP with Member.

1.2.7.5 If the Member declines to participate in ECM:

1.2.7.5.1 Member is informed regarding continuing care with their PCP and obtaining assistance with coordination, as appropriate.

1.2.7.5.2 Member is informed that they may re-engage and receive ECM services at any time in the future as long as he or she continues to meet ECM eligibility requirements.

1.2.7.5.3 Declination is documented in the ECM Provider's care management platform or system of record.

1.2.7.6 AAH monitors, documents, and reports the progress and results of all ECM activities required to be reported to the Department of Health Care Services (DHCS), in accordance with provisions of this policy and any DHCS Program Guide.

2.0 Health Action Plan

2.1 The Health Action Plan (HAP) is a combination of the ECM Assessment and the resultant Care Plan. The combination is known as the HAP (See Related Workflow Documents or Other Attachments).

2.2 ECM Assessment

2.2.1 The ECM Assessment is administered to provide a deeper base of knowledge needed to address complex medical conditions, longer-standing psychosocial or health care needs and gaps. Assessment information will include, but is not limited to:

2.2.1.1 Physical health;
2.2.1.2 Mental health;
2.2.1.3 Substance Use Disorder (SUD);
2.2.1.4 Community-based Services;
2.2.1.5 Palliative care;
2.2.1.6 Trauma-informed care needs;
2.2.1.7 Social Supports;
2.2.1.8 Housing and other Social Determinants of Health; and
2.2.1.9 Utilization

2.2.2 Addressing palliative care and trauma informed care needs

2.2.2.1 The ECM Assessment addresses the following palliative care domains: pain; difficulty taking medications; physical function; social connections; and advance (directive) planning. The Alliance incorporates the elements of palliative care into the ECM Assessment without using the word "palliative."

2.2.2.2 The ECM Assessment addresses the following trauma-informed care domains: safety, mental health, substance use disorder, pain, utilization, and disease burden. The Alliance incorporates the components of trauma-informed care into the ECM Assessment without using the word, "trauma" and uses open-ended questions designed to elicit responses that could include experiences considered to be traumatic.

2.2.2.3 Recognizing that palliative care and trauma-informed-care may be new skill sets for ECM Provider staff, trainings to address and improve palliative care and trauma-informed care assessments will be regularly offered to ECM Providers.

2.2.3 ECM Providers make multiple efforts to contact newly enrolled ECM Members to conduct the ECM Assessment which will be repeated yearly and with any transition in care or other major event.

2.2.4 Following Member consent to enroll, Members identified as higher risk will be prioritized for the outreach and engagement to conduct and complete the ECM Assessment.

2.2.5 For the High Tier priority engagement group, ongoing attempts to contact occurs weekly using multiple modalities such as phone, email, and text (per the Member's documented preference) and at varying times of day and evening, for up to ninety (90) days.

2.2.6 For the Low Tier group, ongoing attempts to contact occurs monthly using multiple modalities and times of day and evening, for up to ninety (90) days.

2.2.7 If unable to contact the Member by phone or mail, every avenue is researched to secure a valid phone number (e.g. the PCP office, specialty care provider office, a vendor where durable medical equipment is rented from, current pharmacy used, or data available on other data exchange platforms, etc.).

2.2.8 The ECM Provider will document all contact attempts in their care management platform or system of record.

2.2.9 To facilitate communication among the Member's health care Providers, the completed ECM Assessment is made available to the entire ECM Provider team and the Member's PCP.

2.2.10 AAH ECM Providers will track, trend, monitor, and report ECM Assessment administration and reassessment practices for all eligible members.

2.3 Care Plan

2.3.1 Once the ECM Assessment is completed, the designated ECM Provider team member develops the Care Plan for each Member enrolled in ECM services in collaboration with the Member, caregiver, and other members of the ECM Provider team.

2.3.2 The designated ECM Provider team member works with the Member to develop and prioritize goals according to the Member's priorities and preferences. Individualized goals will have timeframes and strategies for addressing each goal. Members have the opportunity to be involved in the development, review, and approval of the Care Plan and any amendments to the Care Plan, as appropriate.

2.3.3 The Care Plan is developed using the ECM Assessment data as well as other information available from various sources such as utilization data, pharmacy data, or notes from any AAH Care Management (CM) activities.

2.3.4 The Care Plan will include, but is not limited to, the following elements, as appropriate:

2.3.4.1 Language and communication preferences;

2.3.4.2 Risk level or complexity tier;

2.3.4.3 Housing status;

2.3.4.4 Care team supports, including contact information;

2.3.4.5 Emergency Department (ED)/hospital utilization;

2.3.4.6 Medications and dosage;

2.3.4.7 Any care needs identified on the ECM Assessment pertaining to chronic physical condition, behavioral health status including cognitive functions, developmental health and dementia, trauma-informed care, palliative care needs, and specific goals and action plan;

2.3.4.8 Self-management goals, including barriers to success, interventions, and goal status;

2.3.4.9 Timeframes for reassessment and ECM Provider follow-up frequency;

2.3.4.10 Coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies such as In-Home Supportive Services (IHSS) and Community-Based Adult Services (CBAS);

2.3.4.11 Care coordination and social support needs such as arranging transportation, obtaining appointments, referral tracking and status updates (including housing referrals), coordinating interpreter services, and educating on the importance of preventative services.

2.3.5 The HAP is accessible to all members of the care team:

2.3.5.1 The Member will be provided, upon request, a copy of the

HAP by mail or in person and updates provided during each follow up.

2.3.5.2 The PCP will be given the Member's HAP.

2.3.5.3 Other ECM Provider care team members have access to the HAP and have the ability to update and modify the HAP.

2.3.6 Quarterly, or more frequently if needed, the ECM Provider reviews the HAP with each Member and will reassess and update it with any changes in the Member's progress, status or health care needs and/or according to the HAP follow up plan. A clinician at the ECM Provider reviews the HAP. AAH clinician ensures that appropriate ECM clinician has provided oversight to ensure the HAP is maintained and updated as appropriate through quarterly audits.

2.3.6.1 A care team member reviews utilization reports identifying a Member who has had a recent hospital admission, discharge or ED visit. This will alert them to contact the Member, as appropriate, to review the current HAP and make changes as necessary.

2.3.6.2 The ECM Provider team member reviews the HAP with the Member at each contact to assess the progress made towards the goals identified in the HAP as well as tracks referrals made and follow-up on completion and communication on each referral.

2.3.6.3 The ECM Provider will make updates to the HAP if a goal has changed priority, has been met, or is no longer applicable.

2.3.6.4 The HAP will be completed within ninety (90) days of ECM enrollment.

3.0 Member Ongoing Engagement and Care Management Services

3.1 ECM Provider team members provide ongoing care management support in person and telephonically at a frequency determined by the Member's complexity (Tier level) and desired level of involvement in ECM.

3.2 The ECM Lead Care Manager serves as the primary point of contact and supports activities provided by ECM Providers which include, but are not limited to:

3.2.1 Assessing and managing Members using evidence-based clinical protocols and resources;

3.2.2 Ensuring completion of HAP within specified timeframe;

3.2.3 Documenting Member's choice of caregiver or family/support persons and assisting Members and chosen family/support persons with access to appropriate resources;

3.2.4 Assisting Members and chosen family/support persons with scheduling appointments;

3.2.5 Tracking and monitoring internal and external referrals;

3.2.6 Developing and communicating self-management plans with input from the Member and caregiver(s)/family, as well as helping the member to identify and build on successes and potential family and/or support networks;

3.2.7 Providing appropriate, timely, and actionable Member education to improve self-management skills;

3.2.8 Empowering Members to enhance self-management using Motivational Interviewing techniques;

3.2.9 Using problem-based, comprehensive case planning, with measurable, prioritized goals and interventions tailored to the complexity level of the Member as determined by the initial and ongoing assessments;

3.2.10 Providing care management that is Member-centric and culturally aware;

3.2.11 Interacting with Members and family and / or support persons from a holistic perspective, promoting collaboration and coordination, through all levels of the health care continuum including physical and behavioral health programs, pharmaceutical management, and community-based programs;

3.2.12 Monitoring and supporting treatment adherence (including medication management and reconciliation);

3.2.13 Assisting in attainment of the Member's goals as described in the HAP;

3.2.14 Encouraging the Member's decision-making and continued participation in ECM; and

3.2.15 Accompanying Members to appointments, as needed.

3.3 AAH ensures that the ECM Member's acuity will be the basis for the appropriate provision of ECM services by the ECM Provider. Members in the higher acuity risk groupings (tiers) will receive more intensive ECM services at a higher frequency.

3.3.1 High Risk (High Tier)

3.3.1.1 Attempt weekly contacts with the Member and, at a minimum, one in-person meeting per month. The in-person meeting per month may be temporarily suspended during a declared public health emergency; however, alternative means of communication with the Member should be employed to contact the Member during this time including secure teleconferencing and telehealth visits;

3.3.1.2 On-going communication with PCP regarding HAP updates and information-sharing;

3.3.1.3 Weekly, systematic case reviews by the ECM Provider team (including PCP when needed) for measurement-based care to review the Member's HAP, their progress towards goals, adherence to treatment plan, and make necessary changes in treatment and strategy to engage the Member in their Care Plan; and

3.3.1.4 Documentation of each contact and updates to the HAP will be made in the care management platform or system of record.

3.3.2 Low/Medium Risk (Low Tier)

3.3.2.1 Attempt monthly contacts with the Member;

3.3.2.2 ECM Provider staff can utilize a combination of telephonic and face-to-face encounters, based on the Member's preference, and as documented in the HAP. In-person meeting may be temporarily suspended during a declared public health emergency; however, alternative means of communication with member should be employed to contact member during this time including secure teleconferencing and telehealth visits.

3.3.2.3 On-going communication with PCP regarding HAP updates and information sharing;

3.3.2.4 Periodic systematic case reviews by the ECM Provider team (including PCP when needed) for measurement-based care to review the Member HAP's, their progress towards goals, adherence to treatment plan, and make necessary changes in treatment and strategy to engage the Member in their care plan; and

3.3.2.5 Documentation of each contact and updates to the HAP will be made in the care management platform or system of record.

4.0 Housing

4.1 ECM Members in need of housing services may be identified as follows:

4.1.1 ECM Providers conduct an ECM Assessment upon enrollment, annually, and with any change in status. The ECM Assessment includes questions that identify Members' homelessness or housing instability concerns.

4.1.2 Care team may be alerted to Members' housing concerns through the regular course of providing comprehensive care management services.

4.2 Members experiencing homelessness or housing instability will include goals related to housing on their HAP. Goals may address:

4.2.1 Housing navigation;

4.2.2 Transitional support;

4.2.3 Tenancy support;

4.2.4 Assistance in finding permanent housing.

4.2.4.1 Referrals to housing navigation is a component of the ECM Provider care coordinator's functions.

4.3 AAH will provide the following support to ECM Providers:

4.3.1 Cultivate relationships with local housing agencies including permanent housing providers;

4.3.2 Cultivate relationships with homeless service providers;

4.3.3 Provide advocacy for Members through housing agencies and coalitions; and

4.3.4 Partner with Alameda County Health Care Services Agency (HCSA) and Corporation for Supportive Housing to create and provide educational offerings and technical assistance around housing navigation and tenancy supports, as needed.

5.0 Referral Management

5.1 Referral management is a component of the ECM Provider care coordinator's primary responsibilities. The ECM Provider care coordinator will track, monitor and provide referral coordination for all new, pending or completed referrals captured within the web-based care management platform or equivalent platform.

5.1.1 The ECM Assessment is the opportunity to gather and document relevant information regarding a member's needs, including medical health, behavioral health, palliative care, and social needs.

5.1.2 A member-centered plan of care is generated from the ECM Assessment which includes referrals agreed to by the ECM Member. These referrals may link ECM Members to medical specialty care, primary care, behavioral health, long term care services, palliative care, housing, community supports and any community resources which address the Member's needs.

5.1.3 Referrals may be placed to various services and appropriate community agencies via fax, telephone, in person or through secure electronic methods.

5.1.4 ECM Providers ensure that referrals were received and processed by the receiving agencies or providers, track whether services were received by the ECM Member and document the outcomes of the referrals.

5.1.5 Referrals will be followed up by phone, fax, in person or via secure

electronic pathways, at scheduled intervals, to ensure that a referral has been completed and the ECM Member appropriately linked to services.

5.2 Referral and transition coordination include the following activities:

5.2.1 Provide system navigation and serve as the point of contact for ECM Members and families for questions or concerns related to internal or external referrals;

5.2.2 Review details and expectations about the referral with the Member and/or caregivers;

5.2.3 Gather and send necessary medical information such as clinical background, diagnosis, prognosis, and referral needs, as appropriate, to referral source(s);

5.2.4 Assist Members in problem-solving potential barriers (e.g., request interpreters as appropriate, transportation assistance or community resource assistance);

5.2.5 Ensure that referrals are addressed in a timely manner, as specified by the ordering Provider;

5.2.6 Remind patients of scheduled appointments based on the Member's preference and as documented in the HAP;

5.2.7 Monitor referral activity daily, providing additional assistance to Members who have not completed referrals within specified timeframe, have cancelations, missed appointments, or other reasons for an incomplete referral;

5.2.8 Maintain ongoing tracking and appropriate documentation of referrals to promote care team communication and continuity of care; and

5.2.9 Ensure the Member's health record is up to date with information on specialist consults, hospital summaries, diagnostic results, ED visits and community organization information related to the health of the Member.

6.0 Transitions of Care

6.1 AAH collaborates with ECM Provider staff to coordinate care across all healthcare settings, providers, and services to assure continuity of care.

6.2 ECM Providers, in partnership with AAH, continuously work with all facilities to ensure that Members are receiving comprehensive quality care in the least restrictive setting.

6.3 AAH ensures that ECM Providers have access to daily hospital admission, discharge and ED visit information for ECMMembers.

6.4 Member engagement and Transition of Care (TOC) activities begin during ED visit or hospital admission, when possible.

6.4.1 Upon notification of an ED visit or inpatient hospital admission, the ECM Provider care coordinator begins transition activities for ECM Members. Activities include, but are not limited to:

6.4.1.1 Engaging with the Member during their ED visit or hospitalization, if possible;

6.4.1.2 Engaging with the Member within 48 hours of their ED visit or hospital discharge;

6.4.1.3 Reviewing discharge plan and medication changes;

6.4.1.4 Updating HAP;

6.4.1.5 Referral management and coordination support; and

6.4.1.6 Scheduling timely follow-up appointment(s) with the Member's PCP and specialists, as appropriate.

6.4.1.6.1 Includes arranging transportation for transition care and to medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policies and procedures.

6.4.1.7 Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services.

6.4.1.7.1 When possible, provide transition support to permanent housing.

6.4.1.8 The ECM Provider team contacts the Member to monitor their status before, during and after a transition of care, when possible.

6.4.2 The ECM Provider care coordinator will update the ECM Provider team, or the multidisciplinary care team, who will assist with the coordination and delivery of services or schedule case conferences to discuss supportive measures needed, changes to the HAP, and discussions to prevent future utilization.

6.4.3 ECM Providers have ongoing communication with facilities to monitor Members' needs and the services provided to them.

6.4.3.1 AAH prevents readmissions by utilizing evidence-based best practices for Transitions of Care and encouraging ECM Providers to follow the same. AAH tracks readmissions via an ECM-specific dashboard that is shared with ECM Providers on a regular basis.

7.0 Member Transition to Lower Level of Care/Disenrollment

7.1 ECM Provider teams will continue to reassess the Member's risk status level and programmatic appropriateness.

7.1.1 Members transitioning to ECM from the Health Homes Program (HHP) or Whole Person Care (WPC) Pilot will be reassessed within a period of six (6) months to determine the most appropriate level of services for each Member, whether in ECM or a lower level of care coordination.

7.1.2 When Members have experienced a 6-month period of stability, defined by well managed clinical measures, no hospital or ED utilization and have successfully met their self-management goals on the HAP, they are ready to transition to a lower level of care and disenroll or "graduates" from ECM.

7.1.3 If a Member consented and engaged in ECM but has had no active participation for ninety (90) days, despite ongoing outreach and engagement efforts by the ECM Provider team, the Member will be disenrolled.

7.1.4 If a Member chooses to disenroll for any reason, the Member will be disenrolled.

7.1.5 If a Member is now participating in another program excluding them from ECM eligibility, the Member may choose the alternate program and be disenrolled from ECM.

7.1.6 The disenrollment reason will be documented in the web-based care management platform or equivalent platform.

7.1.7 The ECM provider will notify AAH when the member is ready to transition to a lower level of care. The ECM Provider will use the Alliance Enhanced Care Management Graduation Bundle (Attachment A) to determine when an ECM Member is ready for graduation and ready to transition to a lower level of care. AAH will not be determining the member's readiness for

graduation but will follow the recommendation of the ECM Provider who is providing the direct services. AAH will follow the standard Grievance & Appeals process when a member disputes ECM graduation and transition to a lower level of care.

7.1.8 The provider will provide a warm handoff, when appropriate, to the receiving lower level Care Management provider. Lower level Care Management may include programs at the ECM Provider, or other community Care Management entities, including AAH telephonic Care Management. If the ECM Provider has difficulty locating an appropriate lower level of care provider, the Alliance will assist in identifying an appropriate provider, including acceptance of the member into the AAH telephonic care management program. AAH will work with ECM Provider to graduate the member and transition to a lower level of care when needed.

7.2 The process ECM Providers are expected to use to notify the Alliance when discontinuation criteria are met is through the monthly submission of the DHCS Member Information File. This file includes Disenrollment Reason codes notifying the Plan of discontinuation of delivery (e.g. graduation, disenrollment, unwilling to engage, provider unable to connect after multiple attempts).Upon notification from the ECM Provider, AAH will issue a Notice of Action (NOA) to Members disenrolled from ECM for specific situations. AAH will send the NOA to the Member, ECM provider and PCP within thirty (30) days after the effective date of ECM disenrollment. AAH will send a NOA to the Member, the ECM Provider, and the Member's PCP (if the ECM Provider is not the Member's PCP) if:

7.2.1 The Member develops a change in eligibility such as an exclusionary condition;

7.2.2 The Member's eligible chronic condition(s) become well-managed (for six consecutive months);

7.2.3 The Member has met all care plan goals;

7.2.4 The Member is ready to transition to a lower level of care;

7.2.5 The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or

7.2.6 A Member consents and enrolls, but there is no documented active participation for ninety (90) days despite outreach and engagement efforts as part of care management.

7.2.7 When ECM services are discontinued; the Member or the ECM Provider may request the member be transitioned to a lower level of care management. AAH will work with the ECM Provider to complete a warm handoff to AAH's telephonic Case Management or to a community-based case management program.

7.3 AAH will not send a NOA to a member who chooses to disenroll from ECM.

DEFINITIONS / ACRONYMS

AAH Alameda Alliance for Health
NOA Notice of Action
ECM Enhanced Care Management
HAP Health Action Plan
TOC Transition of Care

WPC Whole Person Care

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
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
UM-016 Transportation Guidelines

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alameda Alliance for Health: ECM Program
ECM Provider ECM Assessment

Staff Person Completing Form:
Date Form Completed:

Demographics

Name:_____

DOB: _____ AAH#:_____ CIN:_____

Type of Assessment: ☐ New ☐ Annual

Race/Ethnicity: ☐ African American/Black ☐ Latino/Hispanic
☐ Asian/Pacific Islander ☐ Native American
☐ Black/Non-Hispanic ☐ White/Non-Hispanic
☐ More than one race/ethnicity
☐ Other: _____

Gender: ☐ Male ☐ Female ☐ Transgender (F->M M->F) ____ ☐ Non-binary ☐ Other _____

Any cultural/religious preferences related to member's healthcare? ☐ Yes ☐ No

Preferred language:_____

*Is anything going on with your health right now that is causing you a lot of stress?
☐ Yes ☐ No

Describe:

How would you describe your overall health?
☐ Excellent
☐ Very Good
☐ Good
☐ Fair
☐ Poor

Physical Environment

***Type of Residence:**
☐ Apartment
☐ House
☐ Assisted Living
☐ SRO (Permanent? Supported?)
☐ SNF
☐ Literally Homeless: If yes, please circle one of the following: car shelter encampment outside solo
☐ Temporary housing - alone
☐ Temporary housing-with friends and/or family
☐ Other:_____

If homeless, when was the last time you were stably housed?
_____

***Transportation:**
Do you have access to transportation?
☐ Yes ☐ No

If no, please describe your ability to access transportation:

***Safety:**
Do you feel safe in your home?
☐ Yes ☐ No

If no, what if anything would help right now?

Current Housing Programs:
☐ Section 8
☐ Housing Authority
☐ None
☐ Unknown
☐ Other: _____

Living Arrangement:
☐ Lives alone
☐ Lives with family/friends
☐ Lives with pet (indicate if certified service animal.

Financial Resources (optional):
Household Income per month (includes income of client and other household members)

Client Income Source:

Employment? Yes ☐ No ☐ Amount ___

SSD Yes ☐ No ☐ Amount ___

SSI Yes ☐ No ☐ Amount ___

Food Stamps Yes ☐ No ☐ Amount ___

TANF Yes ☐ No ☐ Amount ___

Unemployment Yes ☐ No ☐ Amount ___
VA Benefits Yes ☐ No ☐ Amount ___

Gen. Assistance Yes ☐ No ☐ Amount ___

Other Yes ☐ No ☐ Amount ___

Total _____

No Resources (circle if applicable)

Clinical Information

Physical Health Diagnoses (focus on chronic conditions):
_____

Mental Health Diagnoses: _____

Primary Care Physician: _____
Phone Number: _____
Specialty Physician(s): _____
Phone Number: _____
Name of pharmacy/service and contact number (if applicable): _____

Medical Facility most often used (ED/Hospital): _____

*How well do you understand your diagnoses and/or prescriptions? ☐ Not well ☐ Well enough ☐ Very well

*Do you have trouble getting appointments with your primary health care provider? ☐ Yes ☐ No

When was your last visit to Primary Care Provider? _____

When is your next visit to Primary Care Provider? _____

*Do you receive dental care? ☐ Yes ☐ No
If yes name of dentist: _____ Phone number: _____

*Do you have pain when eating? ☐Yes ☐ No

	Yes	No	Details
In last 12 months, have you been to the ER or been hospitalized?	☐	☐	
Have you ever been hospitalized for mental health?	☐	☐	
Have you followed up with doctor since hospitalization?	☐	☐	
	Yes	**No**	**Details**
In last 12 months, have you had any surgeries?	☐	☐	
Have you followed up with doctor since surgery?	☐	☐	

Medications

Do you have any prescription or over-the-counter medications? ☐ Yes ☐ No

Name of medication:	Dose (ex. 5 mg)	Route (by mouth, subcutaneous)	Frequency (daily, weekly, as needed, etc)	Diagnosis	Date filled / expired

*Is there anything that makes it hard to take your medications as prescribed?
Some options below for you and patient to check off. "Do you ever…"

☐ Forget to take medications ☐ Forget to refill prescriptions on time ☐ Doubt the value of your medications ☐ Have problems reading the labels, because they're in the wrong language ☐ Have trouble reading the labels because you can't see well ☐ Have medication side effects	☐ Have difficulty opening pill bottles ☐ Get concerned about drug safety ☐ Get confused about medicines ☐ Have trouble getting to the pharmacy to pick up your medicines ☐ Have trouble affording your medicines ☐ Other: _____

Do you take any herbal remedies? ☐ Yes ☐ No

List any here:

Allergies		**Description**
Seasonal/ Environmental allergies	☐	
Allergies to medications	☐	
Food allergies	☐	

Pain

*Do you have chronic pain? ☐ Yes ☐ No

Details (Include things like location, cause, triggers):

What is the impact of the pain on your daily functioning? ("can you get through your day without interruption or does the pain keep you from doing certain things?")

	0= no pain	1= mild pain	2= moderate pain	3= severe pain	4= very severe pain	5= worst Possible pain
On a pain scale of 0-5 what number would you give your pain right now?	☐	☐	☐	☐	☐	☐
What number would you give your pain	☐	☐	☐	☐	☐	☐

when it is the worst that it gets?						
What number would you give your pain when it is the best that it gets?	☐	☐	☐	☐	☐	☐
At what number is the pain at an acceptable level for you?	☐	☐	☐	☐	☐	☐

Do you take medication for pain? ☐ Yes (which medicines) ☐ No	Does medication relieve the pain? ☐ All of the time ☐ Some of the time ☐ None of the time

Food Security:

*Do you have trouble accessing food?
☐ Yes☐ No

How many meals do you eat each day?
☐ 0-1☐ 2-3☐ 4-5☐ 6+

In the past 12 months have you worried that your food would run out before getting money to buy more?
☐ Yes ☐ No

In the past 12 months has your food run out because you didn't have money to get more?
☐ Yes ☐ No

Functional Assessment:

Hearing/Vision Deficits	**Yes**	**No**	
*Do you have trouble hearing?	☐	☐	Do you have hearing aids? ☐ Yes ☐ No
*Do you have trouble seeing?	☐	☐	Do you wear glasses or contacts? ☐ Yes ☐ No How is your eyesight with glasses/contacts? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Blind

Communication Barriers	**Yes**	**No**	**Notes**
Do you speak English comfortably	☐	☐	
Do you feel your speech is impaired	☐	☐	
Do you feel you have memory loss	☐	☐	
Do you feel you have trouble thinking clearly	☐	☐	

How often do you have someone help you read health care materials? ☐ Always ☐ Sometimes ☐ Never
How confident are you at filling out medical forms by yourself? ☐ Always ☐ Sometimes ☐ Never

Physical Functioning

Stairs:	**Fall Risk**
Any stairs at home? ☐ Yes ☐ No Your ability to climb one flight of stairs: ☐ No difficulty ☐ Difficulty ☐ Unable ☐ N/A – no stairs	*Have you fallen within the last 6 months? ☐ Yes ☐ No If yes, how many times?_____ Do you have fear of falling ☐ Yes ☐ No

☐ N/A – uses ramp, wheelchair, etc	Details:

Level of help needed:						
***ADLs**	**Independent**	**Supervision**	**Assistance**	**Dependent**		**Needs more help**
Bathing	☐	☐	☐	☐		☐
Toileting	☐	☐	☐	☐		☐
Dressing	☐	☐	☐	☐		☐
Walking	☐	☐	☐	☐		☐
Feeding	☐	☐	☐	☐		☐

Any home modifications needed?
☐ Yes ☐ No
Describe modifications needed:

Level of help needed:						
***IADLs**	**Independent**	**Supervision**	**Assistance**	**Dependent**		**Needs more help**
Taking Medications	☐	☐	☐	☐		☐
Hygiene (brushing teeth, brushing hair, shaving)	☐	☐	☐	☐		☐
Housekeeping/Chores	☐	☐	☐	☐		☐
Shopping/Errands	☐	☐	☐	☐		☐
Meal Preparation or Cooking	☐	☐	☐	☐		☐
Accessing Resources	☐	☐	☐	☐		☐
Managing Money	☐	☐	☐	☐		☐
Transportation	☐	☐	☐	☐		☐
Keeping track of appointments	☐	☐	☐	☐		☐
Going out to visit family or friends	☐	☐	☐	☐		☐
Using the phone	☐	☐	☐	☐		☐

*Can you live safely and move easily around in your home? ☐ Yes ☐ No

If No, does the place where you live have:

Good lighting ☐ Yes ☐ No
Good heating ☐ Yes ☐ No
Good cooling ☐ Yes ☐ No
Rails for any stairs or ramps ☐ Yes ☐ No
Hot water ☐ Yes ☐ No
Indoor toilet ☐ Yes ☐ No
A door to the outside that locks ☐ Yes ☐ No
Stairs to get into your home or stairs inside your home ☐ Yes ☐ No
Elevator ☐ Yes ☐ No
Space to use a wheelchair ☐ Yes ☐ No
Clear ways to exit your home ☐ Yes ☐ No

*Do you have family members or others willing and able to help you when you need it?
☐ Yes ☐ No

Who helps you with ADLs/IADLs?

☐ Caregiver/IHSS
☐ Family
☐ Other
☐ No one

*Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No

*Do you always have transportation available to get medical care?

☐ Always
☐ Sometimes
☐ Rarely
☐ Never

Assistive Devices:

Do you use any assistive devices such as a Cane, Walker, Tub/Shower Chair, Ramp, Commode, Raised Toilet Seat, Hospital Bed, Safety Rail, Respiratory Aids, Oxygen, or other? ☐ Yes ☐ No

Details:

*Do you have any problems or concerns with devices used? ☐ Yes ☐ No
Details:

*Do you need any additional assistive devices? ☐ Yes ☐ No
Details:

Home and Community Based Services

***IHSS (In-Home Support Services):** Receives IHSS: ☐ Yes ☐ No

Hours per month: _____ Services provided by IHSS:

☐ Name of IHSS Worker: _____
Is that worker (insert name) a:
☐ Independent Provider
☐ Family Member
☐ Other: _____

CBAS (Community-Based Adult Services):
Do you attend CBAS? ☐ Yes ☐ No

Days per week: _____

If yes, name of CBAS Center you attend:

_____

Other Home & Community Based Services:
Other services received? ☐ Yes ☐ No
List specific organizations used and services received below:

(Examples-home health, meals on wheels)

Substance Use and Behavioral Health:

Substance Use:
I have some questions about your experience with alcohol, cigarettes, marijuana, and other drugs. Some of the substances we'll talk about are prescribed by a doctor, but I will only be focusing on whether you've taken them for reasons other than prescribed or in doses other than prescribed.

In the past 6 months, how often have you used the following:	Never	Once or Twice	Monthly	Weekly	Daily	Date of last use	Is this substance a problem for you?
Alcohol • For men, 5 or more drinks • For women, 4 or more drinks							Yes ☐ No ☐
Cigarettes							Yes ☐ No ☐
Prescription Drugs for Non-Medical Reasons (circle any relevant) • Pain medicines • ADHD medicines (ex Ritalin) • Sleeping pills							Yes ☐ No ☐
Marijuana							Yes ☐ No ☐

Other drugs Cocaine, Meth, Heroin, Hallucinogens (Acid, Mushrooms, PCP, Ecstasy)							Yes ☐ No ☐

***If the client answers that he/she uses any of the above substances, and especially if he/she identifies use as a problem, ask:**

Are you willing to receive a referral to a substance use counselor? ☐ Yes ☐ No

Mental Health:

Are you receiving any psychological counseling or treatment? ☐ Yes ☐ No
Name of provider: _____
How long have you been in treatment? _____
How's it going?

_____

_____

*Are there any life crises affecting you now? ☐ Yes ☐ No
Please describe:

*Would you like to talk to someone about your feelings? ☐ Yes ☐ No
Are you interested in counseling/therapy/support group? ☐ Yes ☐ No

Have you ever received mental health or counseling services in the past? ☐ Yes ☐ No
If yes, name of provider:
Have you ever had a doctor tell you that you had a mental health condition? ☐ Yes ☐ No
If yes, what was that condition?

_____

*Have you had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No

Mood/Depression/Suicide

Over the last 2 weeks:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
How often have you been bothered by having little interest or pleasure in doing things?	☐	☐	☐	☐
How often have you been bothered by feeling down, depressed, or hopeless?	☐	☐	☐	☐
→STOP: * If the answers to one or both of the above questions are ***"More than half the days" or "Nearly every day"*** then complete the next seven questions. Otherwise, skip to the next section, "Social Resources."				
How often have you had trouble falling asleep, or sleeping too much?	☐	☐	☐	☐
How often have you been bothered by feeling tired or having little energy?	☐	☐	☐	☐

How often have you had a poor appetite or overeaten?	☐	☐	☐	☐
How often have you felt bad about yourself, or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
How often have you had trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
How often have you moved or spoken so slowly that other people have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
How often have you had thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Cognitive Function/Dementia (document patient's response)

1. What year is it? _____
2. What month is it? _____
3. Give the patient an address phrase to remember with 5 components – example: John, Smith, 42 High Street, Oakland
4. About what time is it (within one hour)? _____
5. Count backwards from 20-1. _____
6. Say the months of the year in reverse _____
7. Repeat address phrase _____

Social Resources

How often do you see or speak with family or friends?
☐ Daily ☐ Several times per week ☐ Several times per month ☐ Less than once per month ☐ Never

*Over the past month (30 days), how many days have you felt lonely?
☐ Most days (I always feel lonely) ☐ More than half the days (more than 15) ☐ 1 Less than 5 days ☐ None I(I never feel lonely)

Do you participate in any social, faith-based or other community activities? ☐ Yes ☐ No
If so, please name here:

Abuse/Neglect

	Yes	No	Details
*Are you ever afraid of or intimidated by someone in your family or household?	☐	☐	
*Has someone in your family or household ever been verbally abusive or tried to control what you can or cannot do?	☐	☐	
* Are you afraid of anyone or is anyone hurting you (including someone in your household or in your family?	☐	☐	

*Is anyone using your money without your ok?	☐	☐	

Advanced Planning: I'd like to talk with you about something called advance care planning. Have you given thought to the type of medical care you would want to have or not have if you ever became too ill or injured to speak for yourself? That is the purpose of advance care planning, to ensure that you are cared for the way you would want to be, even in times when you are unable to speak for yourself. Did you know you could document your preferences ahead of time so that your care team knows about them? Would you like to talk more about how to do that?

☐ Yes ☐ No

**If patient answers yes, please create a goal for the PCP or nurse/social worker on your team to talk with the patient about Advanced Directive, DPOA, and/or POLST.*

Does anyone help you make healthcare decisions or participate in your care plan?

☐ Yes ☐ No

If yes, who: _____

General Health Questions
*What could you do right now to improve your health?

*What are your top 3 goals and priorities for the next 12 months?
Have you taken any steps to get to these yet?
Any asterisked (*) question on this assessment with a concerning response should be addressed in the HAP. Can be addressed either directly through goal setting, or alternatively through prompts to remind your team to follow up on the issues at a future time.

Clients Name:	Male☐ Female ☐ Other ☐	Date of Birth:
ECM Provider:	Care Coordinators Name:	Care Coordinators Phone:
PCP:	Enrollment Date:	Graduation Date:
Summary: ECM Provider long term goal for client:		
Initial HAP Screenings (if applicable)		
Screen:	Date	Score / Level
Katz ADL		
PHQ-9		
Audit - C		

SMART - **S**pecific **M**easurable **A**chievable **R**elevant **T**ime
Client's Long Term Goal(s):

Initial :		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Three Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Six Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:
Nine Months:		
Start Date:	**Completion Date:**	
Goals/Objectives:	Action Steps:	Status:

Attachment A – Alameda Alliance ECM Graduation Bundle

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 9/19/2023

REFERENCES

ECM Policy Guide (ca.gov)
42 CFR § 441.301 - Contents of request for a waiver. | CFR | US Law | LII / Legal Information Institute (cornell.edu)
APL17-013.pdf (ca.gov)
~~California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021~~

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-013
Policy Name	Enhanced Care Management – Oversight, Monitoring, & Controls
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	07/16/2020
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

In order to provide Enhanced Care Management (ECM) services to eligible Alameda Alliance for Health (AAH) Medi-Cal members, AAH contracts with a network of ECM Providers. AAH ensures that ECM Providers comply with program requirements as outlined in the DHCS-MCP ECM and ILOS Contract and ECM and ILOS Standard Provider Terms and Conditions.

PROCEDURE

1.0 Auditing and Oversight of ECM Provider Activities

1.1 AAH will conduct auditing and oversight of ECM Provider activities through the following:

1.1.1 Monthly monitoring of ECM referrals, enrollment, and reports

1.1.2 Quarterly monitoring of AAH internal reports

1.1.3 Annual ECM Provider onsite visits and case file review

2.0 Monthly Monitoring of ECM Enrollment Data and Reports

2.1 AAH receives ECM enrollment data and reports from ECM Providers.

2.1.1 ECM Provider reports are submitted monthly and are uploaded directly into the AAH SFTP site.

2.2 AAH Analytics team reviews the eligibility and enrollment reports

and provides feedback or requests additional information from ECM Providers:

2.2.1 AAH Analytics team reviews data monthly. AAH Analytics team has 30 days upon receipt of report to review submission for content including, but not limited to, use of the correct report template, reporting period and content.

2.2.1.1 If report does not appear to reflect ECM activities, AAH Analytics team follows-up with the contracted ECM Provider to request clarification. AAH Analytics team will work with ECM Provider to identify solutions and close gaps.

2.2.1.2 If upon requested clarification additional concerns exist, a Corrective Action Plan (CAP) may be required.

2.2.1.3 If a CAP is requested and the ECM Provider does not meet or is unable to meet CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to ensure that ECM Provider is meeting ECM program delivery requirements.

3.0 Quarterly Monitoring of AAH Internal Reports

3.1 AAH collects and tracks operational and clinical data from ECM Providers, as well as internal data in order to manage and evaluate the effectiveness of ECM services provided including:

3.1.1 Collecting and tracking measures and outcome data to be reported as required in CalAIM Program guide

3.1.2 Reviewing Utilization Metrics

3.1.3 Tracking quality measures including HEDIS metrics

3.1.4 Collecting, analyzing and reporting financial measures

3.1.5 Reviewing Grievance and Appeals

3.1.6 Reporting on the measures listed in the Department of Health Care Services (DHCS) templates for reporting, encounters, and supplemental payment files as well as any supplemental reports requested by DHCS.

3.2 AAH's ECM, Analytics and Quality teams utilize information obtained and incorporate ECM data into Plan Quality Activities. AAH staff will utilize information obtained to define and drive improvement through interventions and education with targeted providers who have unique or outlying issues or identified trends.

4.0 ECM Provider Onsite Visits and Case File Reviews

4.1 AAH ECM Staff perform site visits, when possible, in order to evaluate ECM operational and care management activities.

4.1.1 Year 1: AAH staff will perform onsite (when possible) visits at least once during the first year and more frequently if issues are identified through the quarterly reports of ECM Provider activities.

4.1.2 Year 2 and beyond: AAH staff will perform onsite (when possible) visits annually in order to assess ECM activities. Onsite visits will assess both operational and care management activities of the ECM Providers.

4.2 Operational areas to be reviewed include:

4.2.1 Staffing, including Care Management Ratios

4.2.2 Reporting and tracking systems

4.2.3 Program development

4.2.4 Staff training

4.3 Case File Review: At the time of a site visit, a random sample of charts, using 8/30 methodology, will be reviewed for evidence of required ECM Care Management services including:

4.3.1 Outreach and engagement

4.3.2 Comprehensive Care Management

4.3.3 Evidence of Health Action Plan (HAP) completion

4.3.4 Participation of the member in HAP development

4.3.5 Participation of Multidisciplinary team

4.3.6 Comprehensive Transitional Care including HAP update

4.3.7 Communication between Care Team members and PCP

4.3.8 Referral Tracking

4.3.9 Referrals to housing support services, when applicable

4.3.10 Referral to Palliative Care, when applicable

4.3.11 Incorporation of Trauma Informed Care practices

4.4 AAH will work collaboratively with ECM Providers in order to identify and address solutions and resolve any areas of deficiency.

4.5 If a corrective approach to deficiency cannot be agreed upon, then a formal CAP may be required.

4.6 If a CAP is requested and the ECM Provider does not meet or is unable to meet the CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to ensure that the ECM Provider is meeting ECM program delivery requirements.

DEFINITIONS / ACRONYMS

ECM	Enhanced Care Management
AAH	Alameda Alliance for Health
DHCS	Department of Health Care Services
CAP	Corrective Action Plan
HEDIS	Healthcare Effectiveness Data and Information Set
HAP	Health Action Plan

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-012 Health Homes – Housing Services
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

		Comprehensive Care Manageme		Health Assessment and Goals						Care Coordination	
Case Status	Date Enrolled	Are Outreach attempts at least weekly and up to 3 months if needed?	Is outreach varied? (Note types)	Was HAP complete w/ in 90 days?	Has HAP been shared w/ entire care team?	Have all biopsychosocial elements been considered?	Note:Physical; Palliative Care; Mental/Acuity; Social services; Substance Use	Are care plan goal(s) clear, measurable & prioritized w/ member involvement?	Are roles clarified within the care team & documented with contact information?	Is there documented coordination of care with members of care team including medication management?	Is there documented progress on care management goals?

Health Education	Comprehensive Transitional Care	Individual & Family Support Services	Refferals to Community & Social Supports
Has health education, coaching, and linkages been made to member and/or family with appropriate follow-up as needed?	Has comprehensive transitional care planning occurred for this member? (Med rec, f/u appointmen	Has assessment of strengths and needs of member and family occurred and linkages to appropriate support occurred?	Have referral and active engagement to community and social supports occurred?

				Comprehensive Care Manageme		Health Assessment and Goals					
Member Name	Member DOB	Case Status	Date Enrolled	Are Outreach attempts at least weekly and up to 3 months if needed?	Is outreach varied? (Note types)	Was HAP complete w/ in 90 days?	Has HAP been shared w/ entire care team?	Have all biopsychosocial elements been considered?	Note: Physical; Palliative Care; Mental/Acuity; Social services; Substance Use	Are care plan goal(s) clear, measurable & prioritized w/ member involvement?	Are roles clarified within the care team & documented with contact information?

Care Coordination		Health Education	Comprehensive Transitional Care	Individual & Family Support Services	Long-Term Services & Supports	Referrals to Community & Social Supports
Is there documented coordination of care with members of care team including medication management?	Is there documented progress on care management goals?	Has health education, coaching, and linkages been made to member and/or family with appropriate follow-up as needed?	Has comprehensive transitional care planning occurred for this member? (Med rec, f/u appointment	Has assessment of strengths and needs of member and family occurred and linkages to appropriate support occurred?	Has the assessment of LTSS and linkages to appropriate support occurred?	Have referral and active engagement to community and social supports occurred?

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 9/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

Monthly schedule will be established and shared with ECM providers at the beginning of each year for scheduled ECM Provider oversight and monitoring.

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POLICY AND PROCEDURE

Policy Number	CM-013
Policy Name	Enhanced Care Management – Oversight, Monitoring, & Controls
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	07/16/2020
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

In order to provide Enhanced Care Management (ECM) services to eligible Alameda Alliance for Health (AAH) Medi-Cal members, AAH contracts with a network of ECM Providers. AAH ensures that ECM Providers comply with program requirements as outlined in the DHCS-MCP ECM and ILOS Contract and ECM and ILOS Standard Provider Terms and Conditions.

PROCEDURE

1.0 Auditing and Oversight of ECM Provider Activities

1.1 AAH will conduct auditing and oversight of ECM Provider activities through the following:

1.1.1 Monthly monitoring of ECM referrals, enrollment, and reports

1.1.2 Quarterly monitoring of AAH internal reports

1.1.3 Annual ECM Provider onsite visits and case file review

2.0 Monthly Monitoring of ECM Enrollment Data and Reports

2.1 AAH receives ECM enrollment data and reports from ECM Providers.

2.1.1 ECM Provider reports are submitted monthly and are uploaded directly into the AAH SFTP site.

2.2 AAH Analytics team reviews the eligibility and enrollment reports

and provides feedback or requests additional information from ECM Providers:

2.2.1 AAH Analytics team reviews data monthly. AAH Analytics team has 30 days upon receipt of report to review submission for content including, but not limited to, use of the correct report template, reporting period and content.

2.2.1.1 If report does not appear to reflect ECM activities, AAH Analytics team follows-up with the contracted ECM Provider to request clarification. AAH Analytics team will work with ECM Provider to identify solutions and close gaps.

2.2.1.2 If upon requested clarification additional concerns exist, a Corrective Action Plan (CAP) may be required.

2.2.1.3 If a CAP is requested and the ECM Provider does not meet or is unable to meet CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to ensure that ECM Provider is meeting ECM program delivery requirements.

3.0 Quarterly Monitoring of AAH Internal Reports

3.1 AAH collects and tracks operational and clinical data from ECM Providers, as well as internal data in order to manage and evaluate the effectiveness of ECM services provided including:

3.1.1 Collecting and tracking measures and outcome data to be reported as required in CalAIM Program guide

3.1.2 Reviewing Utilization Metrics

3.1.3 Tracking quality measures including HEDIS metrics

3.1.4 Collecting, analyzing and reporting financial measures

3.1.5 Reviewing Grievance and Appeals

3.1.6 Reporting on the measures listed in the Department of Health Care Services (DHCS) templates for reporting, encounters, and supplemental payment files as well as any supplemental reports requested by DHCS.

3.2 AAH's ECM, Analytics and Quality teams utilize information obtained and incorporate ECM data into Plan Quality Activities. AAH staff will utilize information obtained to define and drive improvement through interventions and education with targeted providers who have unique or outlying issues or identified trends.

4.0 ECM Provider Onsite Visits and Case File Reviews

4.1 AAH ECM Staff perform site visits, when possible, in order to evaluate ECM operational and care management activities.

4.1.1 Year 1: AAH staff will perform onsite (when possible) visits at least once during the first year and more frequently if issues are identified through the quarterly reports of ECM Provider activities.

4.1.2 Year 2 and beyond: AAH staff will perform onsite (when possible) visits annually in order to assess ECM activities. Onsite visits will assess both operational and care management activities of the ECM Providers.

4.2 Operational areas to be reviewed include:

4.2.1 Staffing, including Care Management Ratios

4.2.2 Reporting and tracking systems

4.2.3 Program development

4.2.4 Staff training

4.3 Case File Review: At the time of a site visit, a random sample of charts, using 8/30 methodology, will be reviewed for evidence of required ECM Care Management services including:

4.3.1 Outreach and engagement

4.3.2 Comprehensive Care Management

4.3.3 Evidence of Health Action Plan (HAP) completion

4.3.4 Participation of the member in HAP development

4.3.5 Participation of Multidisciplinary team

4.3.6 Comprehensive Transitional Care including HAP update

4.3.7 Communication between Care Team members and PCP

4.3.8 Referral Tracking

4.3.9 Referrals to housing support services, when applicable

4.3.10 Referral to Palliative Care, when applicable

4.3.11 Incorporation of Trauma Informed Care practices

4.4 AAH will work collaboratively with ECM Providers in order to identify and address solutions and resolve any areas of deficiency.

4.5 If a corrective approach to deficiency cannot be agreed upon, then a formal CAP may be required.

4.6 If a CAP is requested and the ECM Provider does not meet or is unable to meet the CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to ensure that the ECM Provider is meeting ECM program delivery requirements.

DEFINITIONS / ACRONYMS

ECM	Enhanced Care Management
AAH	Alameda Alliance for Health
DHCS	Department of Health Care Services
CAP	Corrective Action Plan
HEDIS	Healthcare Effectiveness Data and Information Set
HAP	Health Action Plan

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-012 Health Homes – Housing Services
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

HAP Assessment Tool

A	B	C	D	E	F	G	H	I	J	K	L
		Comprehensive Care Manageme		Health Assessment and Goals						Care Coordination	
Case Status	Date Enrolled	Are Outreach attempts at least weekly and up to 3 months if needed?	Is outreach varied? (Note types)	Was HAP complete w/ in 90 days?	Has HAP been shared w/ entire care team?	Have all biopsychosocial elements been considered?	Note:Physical; Palliative Care; Mental/Acuity; Social services; Substance Use	Are care plan goal(s) clear, measurable & prioritized w/ member involvement?	Are roles clarified within the care team & documented with contact information?	Is there documented coordination of care with members of care team including medication management?	Is there documented progress on care management goals?

Health Education	Comprehensive Transitional Care	Individual & Family Support Services	Refferals to Community & Social Supports
Has health education, coaching, and linkages been made to member and/or family with appropriate follow-up as needed?	Has comprehensive transitional care planning occurred for this member? (Med rec, f/u appointmen	Has assessment of strengths and needs of member and family occurred and linkages to appropriate support occurred?	Have referral and active engagement to community and social supports occurred?

	A	B	C	D	E	F	G	H	I	J	K	L
1					Comprehensive Care Manageme		Health Assessment and Goals					
2	Member Name	Member DOB	Case Status	Date Enrolled	Are Outreach attempts at least weekly and up to 3 months if needed?	Is outreach varied? (Note types)	Was HAP complete w/ in 90 days?	Has HAP been shared w/ entire care team?	Have all biopsychosocial elements been considered?	Note: Physical; Palliative Care; Mental/Acuity; Social services; Substance Use	Are care plan goal(s) clear, measurable & prioritized w/ member involvement?	Are roles clarified within the care team & documented with contact information?

M	N	O	P	Q	R	S
Care Coordination		Health Education	Comprehensive Transitional Care	Individual & Family Support Services	Long-Term Services & Supports	Referrals to Community & Social Supports
Is there documented coordination of care with members of care team including medication management?	Is there documented progress on care management goals?	Has health education, coaching, and linkages been made to member and/or family with appropriate follow-up as needed?	Has comprehensive transitional care planning occurred for this member? (Med rec, f/u appointment	Has assessment of strengths and needs of member and family occurred and linkages to appropriate support occurred?	Has the assessment of LTSS and linkages to appropriate support occurred?	Have referral and active engagement to community and social supports occurred?

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022, 9/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

~~California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021~~

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MONITORING

Monthly schedule will be established and shared with ECM providers at the beginning of each year for scheduled ECM Provider oversight and monitoring.

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POLICY AND PROCEDURE

Policy Number	CM-014
Policy Name	Enhanced Care Management – Operations Non-Duplication
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (AAH) must ensure that members are not enrolled in another state program that provides care coordination services that would preclude them from receiving Enhanced Care Management (ECM) care coordination services.

PROCEDURE

1.0 The process to verify member eligibility in other Medi-Cal care coordination services (not ECM) should include:
- 1.1 Checking available AAH data;
- 1.2 Asking members as part of both the in-person/telephonic member assessment during the eligibility/enrollment process and the assessment/care plan process.

2.0 Based on available data, the ECM Eligibility does not include members who are participating in the following programs:
- 2.1 Members enrolled in a program funded by a 1915(c) Home and Community Based (HCBS) waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), Pediatric Palliative Care (PPC);
- 2.2 Members in a Skilled Nursing Facility (SNF) with a duration longer than

the month of admission and the following month; and

2.3 Members enrolled in a hospice care setting.

3.0 Below is a summary of how ECM intersects with existing Medi-Cal programs that provide care coordination services, organized by the following three categories: Members can receive services through both ECM and the other program; Members must choose ECM or the other program; and Members cannot receive ECM services.

3.1 Members Can Receive Services through BOTH ECM and the Other Program

3.1.1 California Children's Services
Children who are enrolled in the Children's Services program are eligible for the ECM.

3.1.2 Specialty Mental Health and Drug Medi-Cal
DHCS recognizes that coordination of behavioral health services will be a major component of ECM. ECM services are focused on physical health, mental health, Substance Use Disorder (SUD), community-based LTSS, palliative care, social supports, and, as appropriate for individuals experiencing homelessness, housing. In the California ECM structure of Managed Care Plans (MCPs) and ECM Providers, it is expected that direct ECM services for ECM members will primarily occur at the ECM Providers, even though MCPs may play a role.

Therefore, it is important that ECM Providers that have ECM members who receive behavioral health services have the capability to support the various needs of their members.

For ECM members without conditions that are appropriate for specialty mental health treatment, it is anticipated that their physical-health oriented ECM Provider is an appropriate setting for their ECM services. These ECM Providers would typically be affiliated with a MCP.

DHCS and stakeholders have noted that ECM members with conditions that are appropriate for specialty mental health treatment may prefer to receive their primary ECM services from their Mental Health Provider's (MHP) contracted provider acting as a designated ECM Provider. To facilitate care coordination for ECM members through a MHP-designated ECM Provider, Drug Medi-Cal Organized Delivery system (DMC-ODS) or MHP providers may perform ECM Provider ECM responsibilities through a contract with the

MCPs in the county at the discretion of the MCP. This type of entity would perform the ECM Providers ECM responsibilities for an ECM eligible managed care member who 1) qualifies to receive services provided under the Medi-Cal scope of service for this type of entity (MHP or Drug Medi-Cal services); and 2) chooses a county MHP, or county MH/SUD plan, affiliated ECM Provider instead of an ECM Provider affiliated with the MCP. In cases where the MHP serves as both an administrator and a provider of direct services, the MHP could assume the responsibilities of the ECM Provider.

3.1.3 Members maybe enrolled in ECM and receive ILOS services.

4.0 Member Choice: ECM or other case management program

4.1 Targeted Case Management

County-operated Targeted Case Management (TCM) is a comprehensive care coordination program and may be duplicative of ECM. Members who are receiving TCM services have a choice of continuing TCM services or receiving ECM services.

However, TCM provided as part of the County Mental Health Plan (MHP) Specialty Mental Health (SMH) services is not duplicative of ECM. The ECM Provider should ensure that they: 1) coordinate with the SMH TCM provider, and 2) do not duplicate any SMH TCM activities.

4.2 1915(c) Waiver Programs

1915(c) Home and Community Based Services (HCBS) Waiver programs provide services to many Medi-Cal members who will likely also meet the eligibility criteria for ECM. There are comprehensive care management components within these programs that are duplicative of ECM services. Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving ECM services.

The 1915(c) HCBS waiver programs include:
HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), and Pediatric Palliative Care (PPC).

4.3 Cal MediConnect or Fee-for-Service Delivery Systems
(Note to ECM Providers: This section's language is required by the state of California; Alameda County does not offer the Cal MediConnect program.)

Members who are eligible for both Medi-Cal and Medicare are eligible for the ECM. In addition, members who are in the Fee-for-Service Delivery System are also eligible for the ECM. However, ECM is not available in the Cal MediConnect or Fee-for-Service delivery systems. Members have the choice to leave the Cal MediConnect or Fee-for- Service delivery systems to receive all their Medi-Cal services, including ECM services, through a regular Medi-Cal Managed Care Plan.

4.4 Other Comprehensive Care Coordination Programs
Individual MCPs have discretion to determine and designate other comprehensive care coordination programs (not listed in this section) that are duplicative of ECM services, including programs that are operated or overseen by the MCP. Examples include, but are not limited to, MCP Complex Case Management programs and Community-Based Adult Services.

5.0 Members receiving treatment or enrolled in the following programs are not eligible for the ECM:
5.1 Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month and Hospice service recipients are excluded from participation in the ECM.
5.2 Hospice

DEFINITIONS / ACRONYMS

AAH	Alameda Alliance for Health
ECM	Enhanced Care Management
ILOS	In Lieu of Services
DHCS	Department of Health Care Services
HCBS	Home and Community Based
ALW	Assisted Living Waiver
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IHO	In-Home Operations
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NF/AH	Nursing Facility Acute Hospital
PPC	Pediatric Palliative Care
TCM	Targeted Case Management
SNF	Skilled Nursing Facility
DMC-ODS	Drug Medi-Cal Organized Delivery system

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-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, 01/20/2022, 03/22/2022, 6/20/2022,
9/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

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POLICY AND PROCEDURE

Policy Number	CM-014
Policy Name	Enhanced Care Management – Operations Non-Duplication
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	~~9/19/2023~~TBD

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TCM	Targeted Case Management
SNF	Skilled Nursing Facility
DMC-ODS	Drug Medi-Cal Organized Delivery system

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-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

CM-014 Enhanced Care Management – Operations Non-Duplication

None

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 6/20/2022,
9/19/2023

REFERENCES

ECM Policy Guide (ca.gov)

~~California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021~~

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

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POLICY AND PROCEDURE

Policy Number	CM-016
Policy Name	Enhanced Care Management – Staffing
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

1.1 The Enhanced Care Management (ECM) Provider is required to deliver ECM services through a team-based approach through the following core services:

1. Comprehensive Care Management;
2. Care Coordination;
3. Health Promotion;
4. Comprehensive Transitional Care;
5. Individual and Family Support Services; and
6. Referral to Community and Social Supports.

1.2 Contracted ECM teams are multi-disciplinary and include an ECM Director, Clinical Consultant (Primary Care Providers [PCPs] served by the ECM Provider), a Nurse Care Manager, a Behavioral Health Care Manager, a Care Coordinator, and a Community Health Worker. The ECM Provider may add additional staff to the team (e.g. Pharmacist, Dietician) to meet ECM Members' needs.

1.3 The table below describes the roles, functions and minimum credentials of required ECM team members.

Required Team Members	Qualifications	Role
Dedicated Lead Care Manager (ECM Member of by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or	• Oversee provision of ECM services and implementation of Health Action Plan (HAP)

Required Team Members	Qualifications	Role
	nurse	• Offer services where ECM member lives, seeks care or find most easily accessible and within the Managed Care Plan (MCP) guidelines • Connect ECM member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma- informed care practices • Work with hospital staff on discharge plan • Engage eligible ECM members • Accompany ECM member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call ECM member to facilitate ECM member visit with the ECM care coordinator
ECM Director (ECM Provider)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (ECM Provider or MCP)	Clinician consultant(s), who may be a primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed, to assist care coordinator
Community Health Workers (ECM Provider or by contract) (Recommended but not required)	Paraprofessional or peer Advocate Administrative support to care coordinator	• Engage eligible ECM members • Accompany ECM member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-

Required Team Members	Qualifications	Role
		management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Cal ECM member to facilitate ECM visit with care coordinator • Connect ECM member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma-informed care practices • Monitor treatment adherence (including medication)

1.4 The aggregate minimum care coordinator ratio requirement is 40:1 for the whole enrolled ECM population in a County as measured at any point in time.

PROCEDURE

2.1. Alameda Alliance for Health (AAH) provides ECM Providers with the multi-disciplinary care team guidance from the Department of Health Care Services (DHCS) CalAIM Program Guide and asks them to attest that their team could meet the care team qualifications and roles.

2.2 The multi-disciplinary care team consists of staff employed by the ECM Providers that provides ECM funded services. The team will primarily be located at the ECM Provider organization unless there is insufficient staffing to provide the full range of ECM duties. AAH may subcontract with other entities to perform these duties. In addition, AAH may provide, or subcontract with another community-based entity to provide, specific ECM Provider duties to assist an ECM Provider to provide the full range of ECM Provider duties.

2.3 AAH requires that ECM Provider care teams *not* based within Federally Qualified Health Centers (FQHC) will partner with the ECM Member's PCP and that licensed clinical social work (LCSW) supervisors or registered nurses (RNs) will provide clinical and programmatic oversight. Non-licensed staff will liaise with community and health plan pharmacist and nurses as needed.

2.4 Job Descriptions for Care Coordination Staff are developed, as appropriate, and submitted as part of the ECM Provider certification application process.

2.5 The ECM Provider uses a team-based, person-centered approach, where staff collectively uses their skills and knowledge to ensure that culturally and linguistically

competent evidence-based services and supports are employed to address the overall health and wellness of each Member. Each Member should be actively involved with the ECM Provider team in setting goals and participating in his/her care planning. The Member's decisions should drive service needs to be addressed within the written HAP.

2.6 Staffing Ratios and estimated caseloads will be actively managed by AAH through the certification process of ECM Providers as well as on a monthly basis post program launch.

- We will collaborate with our ECM Provider partners to meet the required aggregate minimum care manager ratio of 40:1 for the entire enrolled population. We will work with ECM Provider partners to monitor their staffing ratios.
- We will use tools, such as DHCS assessments and membership information provided by the State, to determine appropriate ECM Provider and internal staffing levels other than care managers to meet ECM member needs.
- We will continuously collaborate with ECM Providers to fill positions to meet the contract requirements and staffing conditions of DHCS.

DEFINITIONS / ACRONYMS

AAH – Alameda Alliance for Health
ECM – Enhanced Care Management
DHCS – Department of Health Care Services
LCSW – Licensed Clinical Social Worker
PCP – Primary Care Provider
HAP – Health Action Plan
MCP – Managed Care Plan

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

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-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, 01/20/2022, 03/22/2022, 6/20/2022, 9/19/2023

REFERENCES

CM-016 Enhanced Care Management – Staffing

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	CM-016
Policy Name	Enhanced Care Management – Staffing
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

1.1 The Enhanced Care Management (ECM) Provider is required to deliver ECM services through a team-based approach through the following core services:

1. Comprehensive Care Management;
2. Care Coordination;
3. Health Promotion;
4. Comprehensive Transitional Care;
5. Individual and Family Support Services; and
6. Referral to Community and Social Supports.

1.2 Contracted ECM teams are multi-disciplinary and include an ECM Director, Clinical Consultant (Primary Care Providers [PCPs] served by the ECM Provider), a Nurse Care Manager, a Behavioral Health Care Manager, a Care Coordinator, and a Community Health Worker. The ECM Provider may add additional staff to the team (e.g. Pharmacist, Dietician) to meet ECM Members' needs.

1.3 The table below describes the roles, functions and minimum credentials of required ECM team members.

Required Team Members	Qualifications	Role
Dedicated Lead Care Manager (ECM Member of by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or	• Oversee provision of ECM services and implementation of Health Action Plan (HAP)

Required Team Members	Qualifications	Role
	nurse	• Offer services where ECM member lives, seeks care or find most easily accessible and within the Managed Care Plan (MCP) guidelines • Connect ECM member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma- informed care practices • Work with hospital staff on discharge plan • Engage eligible ECM members • Accompany ECM member to office visits, as needed and according to MCP guidelines • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call ECM member to facilitate ECM member visit with the ECM care coordinator
ECM Director (ECM Provider)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (ECM Provider or MCP)	Clinician consultant(s), who may be a primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed, to assist care coordinator
Community Health Workers (ECM Provider or by contract) (Recommended but not required)	Paraprofessional or peer Advocate Administrative support to care coordinator	• Engage eligible ECM members • Accompany ECM member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-

Required Team Members	Qualifications	Role
		management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Cal ECM member to facilitate ECM visit with care coordinator • Connect ECM member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma-informed care practices • Monitor treatment adherence (including medication)

1.4 The aggregate minimum care coordinator ratio requirement is 40:1 for the whole enrolled ECM population in a County as measured at any point in time.

PROCEDURE

2.1. Alameda Alliance for Health (AAH) provides ECM Providers with the multi-disciplinary care team guidance from the Department of Health Care Services (DHCS) CalAIM Program Guide and asks them to attest that their team could meet the care team qualifications and roles.

2.2 The multi-disciplinary care team consists of staff employed by the ECM Providers that provides ECM funded services. The team will primarily be located at the ECM Provider organization unless there is insufficient staffing to provide the full range of ECM duties. AAH may subcontract with other entities to perform these duties. In addition, AAH may provide, or subcontract with another community-based entity to provide, specific ECM Provider duties to assist an ECM Provider to provide the full range of ECM Provider duties.

2.3 AAH requires that ECM Provider care teams *not* based within Federally Qualified Health Centers (FQHC) will partner with the ECM Member's PCP and that licensed clinical social work (LCSW) supervisors or registered nurses (RNs) will provide clinical and programmatic oversight. Non-licensed staff will liaise with community and health plan pharmacist and nurses as needed.

2.4 Job Descriptions for Care Coordination Staff are developed, as appropriate, and submitted as part of the ECM Provider certification application process.

2.5 The ECM Provider uses a team-based, person-centered approach, where staff collectively uses their skills and knowledge to ensure that culturally and linguistically

competent evidence-based services and supports are employed to address the overall health and wellness of each Member. Each Member should be actively involved with the ECM Provider team in setting goals and participating in his/her care planning. The Member's decisions should drive service needs to be addressed within the written HAP.

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- We will collaborate with our ECM Provider partners to meet the required aggregate minimum care manager ratio of 40:1 for the entire enrolled population. We will work with ECM Provider partners to monitor their staffing ratios.
- We will use tools, such as DHCS assessments and membership information provided by the State, to determine appropriate ECM Provider and internal staffing levels other than care managers to meet ECM member needs.
- We will continuously collaborate with ECM Providers to fill positions to meet the contract requirements and staffing conditions of DHCS.

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AFFECTED DEPARTMENTS/PARTIES

Health Care Services

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
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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, 01/20/2022, 03/22/2022, 6/20/2022, 9/19/2023

REFERENCES

CM-016 Enhanced Care Management – Staffing

ECM Policy Guide (ca.gov)
~~California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021~~

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MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-018
Policy Name	Enhanced Care Management – Member Notification
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Approval/Revision Date	TBD

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 member notification.

1.2. Member Identification: Members are identified through two methodologies:

1.2.1. ECM Eligibility List: Every month, AAH produces an eligibility list based on the defined criteria of the ECM populations of focus.

1.2.2. Self-Referrals: Members may self-refer into ECM at any time by contacting AAH Member Services, ECM Provider, or any AAH Staff. Member's family member(s), guardian, caregiver, and/or authorized support person(s) may also contact AAH Member Services, ECM Provider, or any AAH Staff. Member must provide authorization to speak with someone on their behalf.

1.2.3. AAH has a no wrong door policy. AAH will accept an ECM referral from Primary Care Providers (PCPs), clinics, community, and county mental health providers, community-based organizations, hospitals, skilled nursing facilities, acute rehabilitation centers, California Children's Services (CCS), foster care offices, Regional Centers, First 5 County Commissions and centers, and local perinatal programs.

1.2.4. AAH uses a closed loop referral system for all ECM referrals. This includes, but is not limited to, tracking where the referral was sent from, which population of focus the member is eligible for, which population of

focus the member is authorized for (if different from initial referral request), which ECM provider will be assigned to this member and confirmation that ECM services have started.

1.2.4.1. For Children/Youth and Pregnant/Postpartum populations of focus, a regular report is generated to monitor these vulnerable populations.

1.2.4.2. Monitoring the referral report will improve communication between AAH and ECM providers to ensure members are being served appropriately.

1.3. Member Notification: All eligible members will receive initial and ongoing notification of ECM services, following DHCs guidelines.

1.3.1. Initial and ongoing Member communications regarding the ECM services will be made in accordance with existing AAH policies and procedures for Member communication including consideration of individual Member communication needs.

1.3.2. Members and Providers will be informed of ECM and how to access the program through all usual communication venues listed in the AAH's Marketing & Communications Plan that the Department of Health Care Services (DHCS) approves annually and per AAH policies and procedures. For Providers, these notifications will include the Provider Newsletter, Provider Manual and Quarterly Updates which are all published on AAH's website and Provider Portal. The Quarterly Updates are also printed and mailed to provider offices.

1.3.3. Member communications will be provided in accordance with requirements by DHCS including those for cultural competency and health literacy standards.

1.3.3.1. AAH requires that subcontracted plans (delegates) use the same process for:

1.3.3.1.1. Informing members, family member(s), guardian, caregiver, and/or other authorized support person(s) about ECM, requesting ECM, status of the request and returned communication.

1.3.3.1.2. Implementing presumptive authorization or pre-authorization of ECM

1.3.4. AAH ensures verbal and written communications to the Provider, Member, family member(s), guardian, caregiver, and/or other authorized support person(s) for UM decisions, are provided using the appropriate approved templates and within the UM timeliness standards.

1.3.4.1. For minors, ECM providers will be required to follow the regulations for minor consent services to obtain, document, and manage the Member's parent/guardian authorization for sharing of Personally Identifiable

Information between AAH, ECM and other providers involved in the provision of member care and communicate data sharing authorization preferences back to AAH.

1.3.5. Authorization of Enhanced Care Management (ECM)

1.3.5.1. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:

- Routine requests not to exceed 5 days
- Expedited requests not to exceed 72 hours

1.3.6. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:

- Provider notification not to exceed 24 hours (oral or written), after decision
- Written notification to provider and member not to exceed 2 working days, after decision

1.4. Members Transitioning from Health Homes & Whole Person Care (WPC)

1.4.1. AAH will work in conjunction with the WPC Lead Entity to develop a list of expected WPC Care Management-enrolled members who will be transitioning to ECM. Once the final Member Transition List (MTL) has been received from DHCS for all eligible HHP/WPC members, a reconciliation will be done against AAH internal data. AAH and the WPC Lead Entity will then work together and come to agreement on the final list of members to transition, including those members who are enrolled after the MTL is received. These Members will be automatically enrolled into ECM.

PROCEDURE

2.1 Member Notification: AAH Members are notified of the ECM benefit

2.1.1 All eligible AAH Members will be initially notified of ECM as a newly covered service for eligible participants prior to implementation of ECM. Notification will be conducted through a direct mail letter. Information will also be provided in a Member Newsletter as well as the member portal on the AAH Website.

2.1.1 Providers will be notified through provider quarterly material, provider orientation, and provider portal on the AAH website.

2.1.2 Initial notification will include:

2.1.2.1 A description of the ECM benefit

2.1.2.2 Eligibility criteria

2.1.2.3 How to access ECM
2.1.2.4 Explanation that participation is voluntary and that Member may opt-out of ECM at any time.

2.1.3 AAH will follow an established procedure to get appropriate regulatory approval before mailing this notification to its Members.

2.1.4 All AAH Members will receive ongoing ECM communication through communications venues listed in AAH's Marketing & Communication Plan that DHCS approves annually. Communication methods include, but are not limited to:
2.1.4.1 Mailing
2.1.4.2 Website
2.1.4.3 Member Handbook (EOC)

2.1.5 Ongoing notification will include:
2.1.5.1 A description of the ECM benefit;
2.1.5.2 Eligibility Criteria;
2.1.5.3 How to access ECM; and
2.1.5.4 Explanation that participation is voluntary, and that the Member may discontinue participation at any time

2.1.6 Written and/or telephonic notification of enrolled HHP & WPC members transitioning to ECM will include:
2.1.6.1 A description of the ECM benefit;
2.1.6.2 Eligibility Criteria;
2.1.6.3 How their service will continue under ECM; and,
2.1.6.4 Explanation that participation is voluntary, and that the Member may discontinue participation at any time

2.1.7 Should a change in HHP/WPC provider be required when transitioning to ECM, a warm handoff will occur between the providers and the member will be notified. In order to mitigate any adverse impacts on the Member during transition, the Member will be engaged so that they may express their preferences and any additional needs they may have.

2.1.8 Members may change their ECM Provider by contacting AAH Member Services at 1- 877-932-2738 or 1-800-735-2929 (TTY) during normal business hours. AAH will accommodate such requests within thirty (30) days, or as soon as possible to meet the Member's needs. AAH staff will facilitate a warm handoff between ECM Providers.

2.1.9 AAH Member and Provider materials are made available through a variety of communication venues listed in AAH's Marketing & Communication Plan that DHCS approves annually. Applicable materials will be updated to incorporate content describing the ECM benefit including the DHCS template for Evidence of Coverage/Disclosure Form. Content will include describing ECM, providing guidance about where to obtain additional information and how to refer Members who may be potentially eligible for the ECM.

DEFINITIONS / ACRONYMS

ECM – Enhanced Care Management
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DHCS – Department of Health Care Services
TCM – Targeted Case Management

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Operations
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
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CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 6/20/2022

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-018
Policy Name	Enhanced Care Management – Member Notification
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Approval/Revision Date	~~03/22/2023~~TBD

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AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Operations
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
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CM-016 Enhanced Care Management – Staffing
HCS-015 Enhanced Care Management – Outreach/Member Engagement
HCS-020 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 6/20/2022

REFERENCES

ECM Policy Guide (ca.gov)

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-021
Policy Name	Community Supports – Asthma Remediation
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing AAH ensures that CS Providers are providing CS Asthma Remediation Services to their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Environmental asthma trigger remediations consist of physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

1.5 Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;

- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;

1.6 The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

1.7 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.7.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.7.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.7.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.7.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 AAH's Asthma Remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediation designed to avoid asthma-related hospitalizations such as:

2.1.1 Identification of environmental triggers commonly found in and around the home, including allergens and irritants;

2.1.2 Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters; and

2.1.3 Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

2.2 When authorizing asthma remediation as a CS, AAH must receive and document the following from the CS Provider:

2.2.1 The participant's current licensed health care provider's order specifying the requested remediation(s);

2.2.2 Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary;

2.2.3 That a home visit has been conducted to determine the suitability of any requested remediation(s). Home visits may be temporarily suspended during a declared health emergency, however, alternative means of communication with member should be employed to contact member during this time.

2.3 Member Identification.

2.3.1 Referral Based CS

2.3.1.1 Monthly, the Analytics department runs a Population Report, using medical and pharmacy data for all members using the specific Asthma Remediation criteria to identify members.

2.3.1.2 The Population Report is provided to the Community Supports (CS) department monthly for further processing.

2.3.1.3 Notification of Eligibility

Members are notified of Asthma Remediation eligibility via written communication.

If no address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all progress in the system of record.

2.4 Referral Based CS

2.4.1.1 Assignment to a CS Provider will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location

2.4.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's caregiver/family, guardian, or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible, will then connect the Member to a CS Provider for the provision of services.

2.4.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.4.2 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.

2.5 Eligibility: Individuals with poorly controlled asthma (as determined by an emergency department visit, hospitalization, or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

2.6 Continuity of Care

2.6.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.6.2 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 (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.6.2.1 AAH offers the CS service which the member received through their prior MCP.

2.6.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.

2.6.3 AAH will automatically authorize the CS service when the above conditions are met.

2.7 Member Request for Asthma Remediation Services

2.7.1 AAH verifies a member's health plan

2.7.1.1 Request is reviewed

2.7.1.2 Approval/Denial determination is made per UM Policy, UM-057, process

2.7.1.3 Member and provider notified in accordance with UM Policy, UM-057, Authorization Service Request

2.7.2 CS services are voluntary and member can agree or choose not to receive the

services without having any impact on their other services or benefits.

2.7.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.7.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.7.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.7.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.7.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.8 Data Sharing

2.8.1 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 authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.8.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.8.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.8.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.8.5 AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.9 Payment

2.9.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.9.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.9.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.9.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.9.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.9.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.10 Restrictions and Limitations

2.10.1 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 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 AAH managed care plan contract.

2.10.1.1 AAH will not use the Asthma Remediation CS if another State Plan service, such as Durable Medical Equipment (DME), is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

2.10.1.2 Asthma remediations must be conducted in accordance with applicable State and local building codes.

2.10.1.3 AAH will ensure individuals will not receive duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.10.1.4 Asthma Remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

2.10.1.5 Asthma Remediation modifications are limited to those that are of

direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

2.10.1.6 Before commencement of a physical adaptation to the home or installation of equipment in the home, AAH will provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

2.10.2 AAH currently contracts with a provider who provides Asthma Remediation services and expects to re-contract with this provider as a CS Provider. This provider currently provides services to children up to the age of 18 but is interested in providing their services to adults in 2022. AAH intends to expand Asthma Remediation to adults through the current provider and/or through other interested and qualified providers as necessary.

2.11 Discontinuing Services

2.11.1 Discontinuing of CS services will be based on:

2.11.1.1 Goals met/improved health status

2.11.1.2 Termination of coverage

2.11.1.3 Unable to establish or maintain contact with a member

2.11.1.4 No longer meets criteria

2.11.1.5 Member/caregiver declines services

2.11.1.6 Death of member

2.11.2 CS provider will submit monthly reports identifying AAH members who have completed the CS service.

2.11.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.12 Licensing / Allowable Providers

2.12.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for asthma self-management education.

2.12.2 CS Providers must have experience and expertise with providing these unique services.

2.12.3 Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

2.12.4 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above

2.12.4.1 CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained

2.12.5 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.

2.12.6 The 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
CB-CME	Community Based Care Management Entity
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-036 Continuity of Care

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/28/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	CM-021
Policy Name	Community Supports – Asthma Remediation
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	~~01/11/2023~~TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing AAH ensures that CS Providers are providing CS Asthma Remediation Services to their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Environmental asthma trigger remediations consist of physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

1.5 Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;

- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;

1.6 The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

1.7 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.7.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.7.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.7.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.7.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 AAH's Asthma Remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediation designed to avoid asthma-related hospitalizations such as:

2.1.1 Identification of environmental triggers commonly found in and around the home, including allergens and irritants;

2.1.2 Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters; and

2.1.3 Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

2.2 When authorizing asthma remediation as a CS, AAH must receive and document the following from the CS Provider:

2.2.1 The participant's current licensed health care provider's order specifying the requested remediation(s);

2.2.2 Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary;

2.2.3 That a home visit has been conducted to determine the suitability of any requested remediation(s). Home visits may be temporarily suspended during a declared health emergency, however, alternative means of communication with member should be employed to contact member during this time.

2.3 Member Identification.

2.3.1 Referral Based CS

2.3.1.1 Monthly, the Analytics department runs a Population Report, using medical and pharmacy data for all members using the specific Asthma Remediation criteria to identify members.

2.3.1.2 The Population Report is provided to the Community Supports (CS) department monthly for further processing.

2.3.1.3 Notification of Eligibility

Members are notified of Asthma Remediation eligibility via written communication.

If no address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all progress in the system of record.

~~2.3.2~~2.4 Referral Based CS

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~~2.3.2.1~~2.4.1.1 Assignment to a CS Provider will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location

~~2.3.2.2~~2.4.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's caregiver/family, guardian, or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible, will then connect the Member to a CS Provider for the provision of services.

~~2.3.2.3~~2.4.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

~~2.3.3~~2.4.2 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.

~~2.4~~2.5 Eligibility: Individuals with poorly controlled asthma (as determined by an emergency department visit, hospitalization, or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

~~2.5~~2.6 Continuity of Care

~~2.5.1~~2.6.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

~~2.5.2~~2.6.2 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 (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

~~2.5.2.1~~2.6.2.1 AAH offers the CS service which the member received through their prior MCP.

~~2.5.2.2~~2.6.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.

~~2.5.3~~2.6.3 AAH will automatically authorize the CS service when the above conditions are met.

~~2.6~~2.7 Member Request for Asthma Remediation Services

~~2.6.1~~2.7.1 AAH verifies a member's health plan

~~2.6.1.1~~2.7.1.1 Request is reviewed

~~2.6.1.2~~2.7.1.2 Approval/Denial determination is made per UM Policy, UM-057, process

~~2.6.1.3~~2.7.1.3 Member and provider notified in accordance with UM Policy,

2.6.22.7.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.6.32.7.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.6.42.7.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.6.4.12.7.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.6.4.1.12.7.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.6.4.22.7.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.72.8Data Sharing

2.7.12.8.1 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 authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.7.22.8.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.7.32.8.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.7.42.8.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

~~2.7.5~~2.8.5 AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

~~2.8~~2.9 Payment

~~2.8.1~~2.9.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

~~2.8.2~~2.9.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

~~2.8.2.1~~2.9.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

~~2.8.2.2~~2.9.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

~~2.8.2.3~~2.9.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

~~2.8.3~~2.9.3 PMPM payments will be provided for applicable CS services (e.g., housing).

~~2.9~~2.10 Restrictions and Limitations

~~2.9.1~~2.10.1 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 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 AAH managed care plan contract.

~~2.9.1.1~~2.10.1.1 AAH will not use the Asthma Remediation CS if another State Plan service, such as Durable Medical Equipment (DME), is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

~~2.9.1.2~~2.10.1.2 Asthma remediations must be conducted in accordance with applicable State and local building codes.

~~2.9.1.3~~2.10.1.3 AAH will ensure individuals will not receive duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.9.1.42.10.1.4 Asthma Remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

2.9.1.52.10.1.5 Asthma Remediation modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

2.9.1.62.10.1.6 Before commencement of a physical adaptation to the home or installation of equipment in the home, AAH will provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

2.9.22.10.2 AAH currently contracts with a provider who provides Asthma Remediation services and expects to re-contract with this provider as a CS Provider. This provider currently provides services to children up to the age of 18 but is interested in providing their services to adults in 2022. AAH intends to expand Asthma Remediation to adults through the current provider and/or through other interested and qualified providers as necessary.

2.1022.11 Discontinuing Services

2.10.12.11.1 Discontinuing of CS services will be based on:

2.10.1.12.11.1.1 Goals met/improved health status

2.10.1.22.11.1.2 Termination of coverage

2.10.1.32.11.1.3 Unable to establish or maintain contact with a member

2.10.1.42.11.1.4 No longer meets criteria

2.10.1.52.11.1.5 Member/caregiver declines services

2.10.1.62.11.1.6 Death of member

2.10.22.11.2 CS provider will submit monthly reports identifying AAH members who have completed the CS service.

2.10.32.11.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.112.12 Licensing / Allowable Providers

2.11.12.12.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization or other organization, as needed. The services will be provided in conjunction with culturally and linguistically

competent means appropriate for asthma self-management education.

~~2.11.2~~2.12.2 CS Providers must have experience and expertise with providing these unique services.

~~2.11.3~~2.12.3 Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

~~2.11.4~~2.12.4 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above

~~2.11.4.1~~2.12.4.1 CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained

~~2.11.5~~2.12.5 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.

~~2.11.6~~2.12.6 The 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
CB-CME	Community Based Care Management Entity
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-036 Continuity of Care

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/28/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-022
Policy Name	Community Supports – Housing Deposits
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options through the Community Supports CS program beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Housing Deposits Services for their CS clients experiencing homelessness and housing instability.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 As indicated in P&P CLS-009,*Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.4.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access

to interpreter services for all limited English proficient (LEP) members.

1.4.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.4.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.

PROCEDURE

2.1 AAH Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

2.1.1 Security deposits required to obtain a lease on an apartment or home.

2.1.2 Set-up fees and/or deposits for utilities or service access and utility arrearages.

2.1.3 First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

2.1.4 First month and last month's rent as required by landlord for occupancy.

2.1.5 Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

2.1.6 Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

2.2 Housing Deposit services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

2.3 AAH services provided will utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Housing Deposit Services will not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

2.4 Member Identification

2.4.1 Report Based CS

2.4.1.1 Monthly, the Analytics department runs a Population Report, using data for all members using the specific Housing criteria to identify members.

2.4.1.2 The Population Report is provided to the Community Supports (CS) department monthly for further processing.

2.4.1.3 Notification of Eligibility
Members are notified of Housing eligibility via written communication.
If not address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all process in the system of record.

2.5 Referrals Based CS

2.5.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.5.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver, or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility then connect the Member to a CS Provider for the provision of services.

2.5.2.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.5.3 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.

2.6 Request for Housing Deposit Services

2.6.1 Once AAH verifies a member's health plan eligibility.

2.6.1.1 Request is reviewed

2.6.1.2 Approval/Denial determination is made per UM Policy, UM-057 process

2.6.1.3 Member and provider are notified in accordance with UM Policy, UM-057, Authorization Service Request.

2.6.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.6.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an

automated solution is implemented.

2.6.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.6.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.6.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.6.5 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.7 Continuity of Care

2.7.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.7.2 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 (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.7.2.1 AAH offers the CS service which the member received through their prior MCP.

2.7.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.

2.7.3 AAH will automatically authorize the CS service when the above conditions are met.

2.8 Data Sharing

2.8.1 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 authorization. Data

may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.8.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.8.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.8.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.8.5 AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS's guidelines.

2.9 Eligibility

2.7.1 Any AAH member who received Housing Transition/Navigation Services CS in Alameda County.

2.7.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.7.3 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.7.4 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.7.4.1 In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.7.4.2 By the Department of Housing and Urban Development (HUD) in 24 CFR

91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.7.4.2.1 A ‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.7.4.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.7.4.2.1.2 Has been homeless and living as described in paragraph (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.7.4.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph of this definition, before entering that facility; or

2.7.4.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.7.5 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.7.5.1 (1) An individual or family who:

2.7.5.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.7.5.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

2.7.5.1.2.1 Meets one of the following conditions:

2.7.5.1.2.1.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.7.5.1.2.1.2 Is living in the home of another because of economic hardship;

2.7.5.1.2.1.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.7.5.1.2.1.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.7.5.1.2.1.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.7.5.1.2.1.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.7.5.1.2.1.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.7.5.2 (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.7.5.3 (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.7.6 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.7.6.1 Have one or more serious chronic conditions;

2.7.6.2 Have a Serious Mental Illness;

2.7.6.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.7.6.4 Have a Serious Emotional Disturbance (children and adolescents);

2.7.6.5 Are receiving Enhanced Care Management; or

2.7.6.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.8 Payment

2.8.1 AAH receives payment from DHCS and disperses funds in a timely manner to CS Providers through collection and submission of data by the CS Provider, and through the contractual agreement made between AAH and the CS Provider.

2.8.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.8.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.8.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.8.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.8.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.9 Restrictions and Limitations

2.9.1 Community Supports (CS) 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. In lieu of service can only be covered by AAH if:

2.9.1.1 The State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service;

2.9.1.2 Beneficiaries are not required to use the in lieu of service; and

2.9.1.3 The in lieu of service is authorized and identified in the AAH plan contracts.

2.9.2 Housing Deposits will be available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. AAH will make a good faith effort to review information available to them to determine if individual has previously received services.

2.9.3 These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.

2.9.4 Individuals will also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

2.9.5 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.

2.10 Discontinuing Services

2.10.1 Discontinuing of CS services will be based on:

2.10.1.1 Meeting the lifetime maximum financial limitation

2.10.1.2 Goals met/completion of housing deposit

2.10.1.3 No longer meets criteria

2.10.1.4 Member/caregiver declines services

2.10.1.5 Death of member

2.10.2 CS provider will submit weekly reports identifying AAH members who have completed the CS service.

2.10.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.11 Licensing and Allowable Providers

2.11.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.11.2 The entity that is coordinating an individual's Housing Transition Navigation Services, or AAH's case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

2.11.3 AAH will ensure CS Providers have demonstrated or verifiable experience and expertise with providing these unique services.

2.11.4 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.

2.11.5 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 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
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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	CM-022
Policy Name	Community Supports – Housing Deposits
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	~~01/11/2023~~TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options through the Community Supports CS program beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Housing Deposits Services for their CS clients experiencing homelessness and housing instability.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 As indicated in P&P CLS-009,*Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.4.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access

to interpreter services for all limited English proficient (LEP) members.

1.4.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.4.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.

PROCEDURE

2.1 AAH Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

2.1.1 Security deposits required to obtain a lease on an apartment or home.

2.1.2 Set-up fees and/or deposits for utilities or service access and utility arrearages.

2.1.3 First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

2.1.4 First month and last month's rent as required by landlord for occupancy.

2.1.5 Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

2.1.6 Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

2.2 Housing Deposit services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

2.3 AAH services provided will utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Housing Deposit Services will not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

2.4 Member Identification

2.4.1 Report Based CS

2.4.1.1 Monthly, the Analytics department runs a Population Report, using data for all members using the specific Housing criteria to identify members.

2.4.1.2 The Population Report is provided to the Community Supports (CS) department monthly for further processing.

2.4.1.3 Notification of Eligibility
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If not address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all process in the system of record.

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2.7.3 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

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2.7.4.1 In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been

continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

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2.7.4.2.1 A 'homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.7.4.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.7.4.2.1.2 Has been homeless and living as described in paragraph (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.7.4.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph of this definition, before entering that facility; or

2.7.4.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

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2.7.5.1 (1) An individual or family who:

2.7.5.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.7.5.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and

2.7.5.1.2.1 Meets one of the following conditions:

2.7.5.1.2.1.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.7.5.1.2.1.2 Is living in the home of another because of economic hardship;

2.7.5.1.2.1.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.7.5.1.2.1.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.7.5.1.2.1.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.7.5.1.2.1.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.7.5.1.2.1.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.7.5.2 (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.7.5.3 (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.7.6 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.7.6.1 Have one or more serious chronic conditions;

2.7.6.2 Have a Serious Mental Illness;

2.7.6.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.7.6.4 Have a Serious Emotional Disturbance (children and adolescents);

2.7.6.5 Are receiving Enhanced Care Management; or

2.7.6.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.8 Payment

2.8.1 AAH receives payment from DHCS and disperses funds in a timely manner to CS Providers through collection and submission of data by the CS Provider, and through the contractual agreement made between AAH and the CS Provider.

2.8.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.8.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.8.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.8.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.8.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.9 Restrictions and Limitations

2.9.1 Community Supports (CS) 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. In lieu of service can only be covered by AAH if:

2.9.1.1 The State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service;

2.9.1.2 Beneficiaries are not required to use the in lieu of service; and

2.9.1.3 The in lieu of service is authorized and identified in the AAH plan contracts.

2.9.2 Housing Deposits will be available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. AAH will make a good faith effort to review information available to them to determine if individual has previously received services.

2.9.3 These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.

2.9.4 Individuals will also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

2.9.5 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.

2.10 Discontinuing Services

2.10.1 Discontinuing of CS services will be based on:

2.10.1.1 Meeting the lifetime maximum financial limitation

2.10.1.2 Goals met/completion of housing deposit

2.10.1.3 No longer meets criteria

2.10.1.4 Member/caregiver declines services

2.10.1.5 Death of member

2.10.2 CS provider will submit weekly reports identifying AAH members who have completed the CS service.

2.10.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.11 Licensing and Allowable Providers

2.11.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.11.2 The entity that is coordinating an individual's Housing Transition Navigation Services, or AAH's case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

2.11.3 AAH will ensure CS Providers have demonstrated or verifiable experience and expertise with providing these unique services.

2.11.4 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.

2.11.5 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 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
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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CM-023
Policy Name	Community Supports – Housing Tenancy and Sustaining Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS – Housing Tenancy and Sustaining Services for their CS clients experiencing homelessness and housing instability.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.4.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.4.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.4.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.

PROCEDURE

2.1 AAH provides tenancy and sustaining services through their CS network of providers, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

2.1.1 Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

2.1.2 Education and training on the role rights and responsibilities of the tenant and landlord.

2.1.3 Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

2.1.4 Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

2.1.5 Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.

2.1.6 Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

2.1.7 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

2.1.8 Assistance with the annual housing recertification process.

2.1.9 Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

2.1.10 Continuing assistance with lease compliance, including ongoing support with activities

related to household management.

2.1.11 Health and safety visits, including unit habitability inspections.

2.1.12 Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

2.1.13 Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

2.2 Housing Tenancy and Sustaining Services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

2.3 AAH provided services will utilize best practices for clients who are experiencing homelessness and/or who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.4 AAH will coordinate services with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

2.5 Housing Tenancy and Sustaining Services do not include the provision of room and board or payment of rental costs. Please see housing deposits CS.

2.6 Member Identification

2.6.1 Report Based CS

2.6.1.1 Monthly, the Analytics department runs a Population Report, using data from all members using the specific Housing criteria to identify members.

2.6.1.2 The Population Report is provided to the Community Supports (CS) department monthly for further processing.

2.6.1.2.1 Notification of Eligibility

2.6.1.2.1.1 Member are notified of Housing eligibility via written communication.

2.6.1.2.1.2 If no address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all progress in the system of record.

2.6.2 Referral Based CS

2.6.3 Assignment to CS Providers will be determined using factors, including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.6.4 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized

representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible, will then connect the Member to a CS Provider for the provision of services.

2.6.4.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.6.5 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.

2.7 Request for Housing Tenancy and Sustaining Services

2.7.1 AAH verifies a member's health plan eligibility

2.7.1.1 Request is reviewed

2.7.1.2 Approval/Denial determination is made per UM Policy, UM-057 process

2.7.1.3 Member and provider are notified in accordance with UM Policy, UM-057, Authorization Service Request.

2.7.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.7.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.7.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.7.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.7.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.7.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.8 Continuity of Care

2.8.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy

through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.8.2 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 (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.8.2.1 AAH offers the CS service which the member received through their prior MCP.

2.8.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.

2.8.3 AAH will automatically authorize the CS service when the above conditions are met.

2.9 Data Sharing

2.9.1 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 authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.9.2 AAH CS Clinical Staff and Analytics Staff support CS Provider(s) with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.9.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.9.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.9.5 AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.10 Payment

2.10.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.10.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.10.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.10.2.2 AAH will pay or deny 95% of clean claims within 45 working days of

receipt

2.10.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.10.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.11 Eligibility

2.11.1 Any individual who received Housing Transition/Navigation Services CS in counties that offer Housing Transition/Navigation Services.

2.11.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.11.3 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.11.4 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.11.4.1 In W&I Code section 14127I as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.11.4.2 By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.11.4.2.1 A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.11.4.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.11.4.2.1.2 Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.11.4.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

2.11.4.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.11.5 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.11.5.1 (1) An individual or family who:

2.11.5.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.11.5.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

2.11.5.1.2.1 Meets one of the following conditions:

2.11.5.1.2.1.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.11.5.1.2.1.2 Is living in the home of another because of economic hardship;

2.11.5.1.2.1.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.11.5.1.3 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.11.5.1.4 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.11.5.1.5 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.11.5.1.6 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.11.5.2 (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.11.5.3 (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.11.6 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.11.6.1 Have one or more serious chronic conditions;

2.11.6.2 Have a Serious Mental Illness;

2.11.6.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.11.6.4 Have a Serious Emotional Disturbance (children and adolescents);

2.11.6.5 Are receiving Enhanced Care Management; or

2.11.6.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

2.11.7 Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.12 Restrictions / Limitations

2.12.1 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 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 AAH plan contracts.

2.12.2 Housing Tenancy and Sustaining Services will be available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. AAH will make a good faith effort to review information available to them to determine if individual has previously received services. Service duration can be as long as necessary.

2.12.3 These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

2.12.4 Many individuals will have also received Housing Transition Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

2.12.5 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.

2.13 Discontinuing Services

2.13.1 Discontinuing of CS services will be based on:

2.13.1.1 Goals met/completion of housing support plan

2.13.1.2 Termination of coverage

2.13.1.3 Unable to maintain contact with member

2.13.1.4 No longer meets criteria

2.13.1.5 Member/caregiver declines services

2.13.1.6 Death of member

2.13.2 CS provider will submit weekly reports identifying AAH members who have completed the CS service.

2.13.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.14 Licensing / Allowable Providers

2.14.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.14.2 If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. AAH will coordinate with county homelessness entities to provide these services.

2.14.3 Clients who meet the eligibility requirements for Housing and Tenancy Support Services will also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers. When clients receive more than one of these services, AAH will ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

2.14.4 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.

2.14.5 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 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.

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Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	~~01/11/2023~~TBD

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1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.4.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.4.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

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PROCEDURE

2.1 AAH provides tenancy and sustaining services through their CS network of providers, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

2.1.1 Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

2.1.2 Education and training on the role rights and responsibilities of the tenant and landlord.

2.1.3 Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

2.1.4 Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

2.1.5 Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.

2.1.6 Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

2.1.7 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

2.1.8 Assistance with the annual housing recertification process.

2.1.9 Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

2.1.10 Continuing assistance with lease compliance, including ongoing support with activities

related to household management.

2.1.11 Health and safety visits, including unit habitability inspections.

2.1.12 Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

2.1.13 Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

2.2 Housing Tenancy and Sustaining Services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

2.3 AAH provided services will utilize best practices for clients who are experiencing homelessness and/or who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.4 AAH will coordinate services with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

2.5 Housing Tenancy and Sustaining Services do not include the provision of room and board or payment of rental costs. Please see housing deposits CS.

2.6 Member Identification

2.6.1 Report Based CS

2.6.1.1 Monthly, the Analytics department runs a Population Report, using data from all members using the specific Housing criteria to identify members.

2.6.1.2 The Population Report is provided to the Community Supports (CS) department monthly for further processing.

2.6.1.2.1 Notification of Eligibility

2.6.1.2.1.1 Member are notified of Housing eligibility via written communication.

2.6.1.2.1.2 If no address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all progress in the system of record.

2.6.2 Referral Based CS

2.6.3 Assignment to CS Providers will be determined using factors, including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.6.4 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized

representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible, will then connect the Member to a CS Provider for the provision of services.

2.6.4.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.6.5 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.

2.7 Request for Housing Tenancy and Sustaining Services

2.7.1 AAH verifies a member's health plan eligibility

2.7.1.1 Request is reviewed

2.7.1.2 Approval/Denial determination is made per UM Policy, UM-057 process

2.7.1.3 Member and provider are notified in accordance with UM Policy, UM-057, Authorization Service Request.

2.7.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.7.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.7.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.7.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.7.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.7.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.8 Continuity of Care

2.8.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy

through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.8.2 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 (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.8.2.1 AAH offers the CS service which the member received through their prior MCP.

2.8.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.

2.8.3 AAH will automatically authorize the CS service when the above conditions are met.

2.9 Data Sharing

2.9.1 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 authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.9.2 AAH CS Clinical Staff and Analytics Staff support CS Provider(s) with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.9.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.9.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.9.5 AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.10 Payment

2.10.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.10.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.10.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.10.2.2 AAH will pay or deny 95% of clean claims within 45 working days of

receipt

2.10.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.10.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.11 Eligibility

2.11.1 Any individual who received Housing Transition/Navigation Services CS in counties that offer Housing Transition/Navigation Services.

2.11.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.11.3 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.11.4 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.11.4.1 In W&I Code section 14127I as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.11.4.2 By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.11.4.2.1 A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.11.4.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.11.4.2.1.2 Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.11.4.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

2.11.4.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.11.5 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.11.5.1 (1) An individual or family who:

2.11.5.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.11.5.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

2.11.5.1.2.1 Meets one of the following conditions:

2.11.5.1.2.1.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.11.5.1.2.1.2 Is living in the home of another because of economic hardship;

2.11.5.1.2.1.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.11.5.1.3 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.11.5.1.4 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.11.5.1.5 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.11.5.1.6 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.11.5.2 (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.11.5.3 (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.11.6 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.11.6.1 Have one or more serious chronic conditions;

2.11.6.2 Have a Serious Mental Illness;

2.11.6.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.11.6.4 Have a Serious Emotional Disturbance (children and adolescents);

2.11.6.5 Are receiving Enhanced Care Management; or

2.11.6.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

2.11.7 Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.12 Restrictions / Limitations

2.12.1 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 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 AAH plan contracts.

2.12.2 Housing Tenancy and Sustaining Services will be available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. AAH will make a good faith effort to review information available to them to determine if individual has previously received services. Service duration can be as long as necessary.

2.12.3 These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

2.12.4 Many individuals will have also received Housing Transition Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

2.12.5 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.

2.13 Discontinuing Services

2.13.1 Discontinuing of CS services will be based on:

2.13.1.1 Goals met/completion of housing support plan

2.13.1.2 Termination of coverage

2.13.1.3 Unable to maintain contact with member

2.13.1.4 No longer meets criteria

2.13.1.5 Member/caregiver declines services

2.13.1.6 Death of member

2.13.2 CS provider will submit weekly reports identifying AAH members who have completed the CS service.

2.13.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.14 Licensing / Allowable Providers

2.14.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.14.2 If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. AAH will coordinate with county homelessness entities to provide these services.

2.14.3 Clients who meet the eligibility requirements for Housing and Tenancy Support Services will also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers. When clients receive more than one of these services, AAH will ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

2.14.4 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.

2.14.5 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 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
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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-024
Policy Name	Community Supports – Housing Transition Navigation Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS Housing Transition and Navigation Services for their CS clients experiencing homelessness and housing instability.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 As indicated in P&P CLS-009,*Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can

meet the cultural, language, age and disability needs of our members.

1.4.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.4.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.4.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.

PROCEDURE

2.1 AAH provides Housing Transition Navigation services through their CS network of providers, with a goal of assisting members with housing transition and navigation services. Services include:

2.1.1 Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.

2.1.2 Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.

2.1.3 Searching for housing and presenting options.

2.1.4 Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

2.1.5 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

2.1.6 Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members.

2.1.7 If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental

modifications, moving costs, and other one-time expenses.

2.1.8 Assisting with requests for reasonable accommodation, if necessary.

2.1.9 Landlord education and engagement.

2.1.10 Ensuring that the living environment is safe and ready for move-in.

2.1.11 Communicating and advocating on behalf of the client with landlords.

2.1.12 Assisting in arranging for and supporting the details of the move.

2.1.13 Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2.1.14 Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.

2.1.15 Identifying, coordinating, securing or funding environmental modifications to install necessary accommodations for accessibility.

2.2 Housing Transition Navigation Services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

2.3 AAH services provided will utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.

2.4 AAH will coordinate services with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, AAH will work closely with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. AAH and its contracted CS Providers will coordinate access to housing resources (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) through county behavioral health when appropriate.

2.5 Services do not include the provision of room and board or payment of rental costs. AAH will coordinate with local entities to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

2.6 Member Identification.

AAH identifies eligible members through the following mechanisms:

2.6.1 Report Based CS

2.6.1.0 Monthly, the Analytics department runs a Population Report, using data for

all members using the specific Housing criteria to identify members.

2.6.1.1 The Population Report is provided to the Community Supports (CS) department monthly for further processing.

2.7 Notification of Eligibility

2.7.1 Members are notified of Housing eligibility via written communication.

2.7.2 If no address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all progress in the system of record.

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2.8.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.8.2 A Provider, health plan staff, CS staff, other non-provider community entity, Member themselves, or a Member's caregiver/family may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible, will then connect the Member to a CS Provider for the provision of services.

2.8.2.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.8.3 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.

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2.9.1 AAH verifies a member's health plan eligibility.

2.9.1.1 Request is reviewed

2.9.1.2 Approval/Denial determination is made per UM Policy, 057 process

2.9.1.3 Member and provider are notified in accordance with UM Policy, 057, Authorization Service Request.

2.9.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

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2.9.4.1 If the member is enrolled in ECM, the referral would be sent back to the

ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.9.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

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2.10.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

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2.11.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.11.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.11.5 AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.12 Eligibility

2.12.1 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.12.2 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.12.3 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.12.3.1 In W&I Code section 14127I as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.12.3.2 By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.12.3.2.1 A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.12.3.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.12.3.2.1.2 Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined

occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.12.3.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

2.12.3.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.12.4 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.12.4.1 (1) An individual or family who:

2.12.4.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.12.4.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and

2.12.4.1.3 Meets one of the following conditions:

2.12.4.1.3.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.12.4.1.3.2 Is living in the home of another because of economic hardship;

2.12.4.1.3.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.12.4.1.3.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.12.4.1.3.5 Lives in a single-room occupancy or efficiency apartment unit in

which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.12.4.1.3.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.12.4.1.3.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.12.4.1.4 (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.12.4.1.5 (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.12.5 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.12.5.1 Have one or more serious chronic conditions;

2.12.5.2 Have a Serious Mental Illness;

2.12.5.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.12.5.4 Have a Serious Emotional Disturbance (children and adolescents);

2.12.5.5 Are receiving Enhanced Care Management; or

2.12.5.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

2.12.6 Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior

to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.13 Payment

2.13.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.13.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.13.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.13.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.13.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.13.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.14 Restrictions and Limitations

2.14.1 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 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 AAH plan contracts.

2.14.2 Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan. Service duration can be as long as necessary. AAH will ensure that individuals are not receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.15 Discontinuing Services

2.15.1 Discontinuing of CS services will be based on:

2.15.1.1 Goals met/obtain permanent housing

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2.15.1.5 Member/caregiver declines services

2.15.1.6 Death of member

2.15.2 CS provider will submit weekly reports identifying AAH members who have

completed the CS service.

2.15.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.16 Licensing / Allowable Providers

2.16.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.16.2 Clients who meet the eligibility requirements for Housing Transition/Navigation services will also be assessed for Community Supports Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers. When clients receive more than one of these services, AAH will ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

2.16.3 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.

2.16.4 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 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

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CRE-018 Assessment of Community Supports Organizational Providers

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	CM-024
Policy Name	Community Supports – Housing Transition Navigation Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	~~01/11/2023~~TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS Housing Transition and Navigation Services for their CS clients experiencing homelessness and housing instability.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 As indicated in P&P CLS-009,*Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can

meet the cultural, language, age and disability needs of our members.

1.4.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.4.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.4.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.

PROCEDURE

2.1 AAH provides Housing Transition Navigation services through their CS network of providers, with a goal of assisting members with housing transition and navigation services. Services include:

2.1.1 Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.

2.1.2 Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.

2.1.3 Searching for housing and presenting options.

2.1.4 Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

2.1.5 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

2.1.6 Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members.

2.1.7 If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental

modifications, moving costs, and other one-time expenses.

2.1.8 Assisting with requests for reasonable accommodation, if necessary.

2.1.9 Landlord education and engagement.

2.1.10 Ensuring that the living environment is safe and ready for move-in.

2.1.11 Communicating and advocating on behalf of the client with landlords.

2.1.12 Assisting in arranging for and supporting the details of the move.

2.1.13 Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

2.1.14 Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.

2.1.15 Identifying, coordinating, securing or funding environmental modifications to install necessary accommodations for accessibility.

2.2 Housing Transition Navigation Services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

2.3 AAH services provided will utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.

2.4 AAH will coordinate services with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, AAH will work closely with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. AAH and its contracted CS Providers will coordinate access to housing resources (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) through county behavioral health when appropriate.

2.5 Services do not include the provision of room and board or payment of rental costs. AAH will coordinate with local entities to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

2.6 Member Identification.

AAH identifies eligible members through the following mechanisms:

2.6.1 Report Based CS

~~2.6.1.0~~2.6.1.1 Monthly,

the Analytics department runs a Population Report, using data for all members using the specific Housing criteria to identify members.

~~2.6.1.1~~2.6.1.2 The Population Report is provided to the Community Supports (CS) department monthly for further processing.

2.7 Notification of Eligibility

2.7.1 Members are notified of Housing eligibility via written communication.

2.7.2 If no address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all progress in the system of record.

2.8 Referral Based CS

2.8.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.8.2 A Provider, health plan staff, CS staff, other non-provider community entity, Member themselves, or a Member's caregiver/family may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible, will then connect the Member to a CS Provider for the provision of services.

2.8.2.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.8.3 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.

2.9 Request for Housing Transition Navigation Services

2.9.1 AAH verifies a member's health plan eligibility.

2.9.1.1 Request is reviewed

2.9.1.2 Approval/Denial determination is made per UM Policy, 057 process

2.9.1.3 Member and provider are notified in accordance with UM Policy, 057, Authorization Service Request.

2.9.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.9.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.9.4 If the member does not meet eligibility criteria for the CS service and the

servicing provider cannot supply alternative resources:

2.9.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

~~2.9.4.1.1~~ In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.9.4.1.1

~~2.9.4.2~~ If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

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2.9.4.1.2

2.10 Continuity of Care

2.10.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.10.2 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 (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.10.2.1 AAH offers the CS service which the member received through their prior MCP.

2.10.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.

2.10.3 AAH will automatically authorize the CS service when the above conditions are met.

2.11 Data Sharing

2.11.1 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 authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.11.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional

data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.11.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.11.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.11.5 AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.12 Eligibility

2.12.1 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.12.2 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.12.3 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.12.3.1 In W&I Code section 14127I as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.12.3.2 By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.12.3.2.1 A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.12.3.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.12.3.2.1.2 Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.12.3.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

2.12.3.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

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2.12.4.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

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2.12.4.1.3 Meets one of the following conditions:

2.12.4.1.3.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

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2.12.4.1.3.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after

the date of application for assistance;

2.12.4.1.3.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.12.4.1.3.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

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2.16.2 Clients who meet the eligibility requirements for Housing Transition/Navigation services will also be assessed for Community Supports Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers. When clients receive more than one of these services, AAH will ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

2.16.3 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.

2.16.4 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 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

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services

Finance

RELATED POLICIES AND PROCEDURES

CRE-018 Assessment of Community Supports Organizational Providers

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-025
Policy Name	Community Supports – Medically Supportive Food/Meals/Medically Tailored Meals
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS Medically Supportive Food/Meals/Medically Tailored Meals to their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.4.2 The Provider Services Department ensures compliance of providers and

subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.4.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.4.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 AAH Medically Supportive Food/Meals/Medically Tailored Meals may include:

2.1.1 Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.

2.1.2 Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.

2.1.3 Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

2.1.4 Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers, and food pharmacies.

2.1.5 Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

2.2 Member Identification

2.2.1 Report Based CS

2.2.1.1 AAH Analytics produces a monthly Population Report, using medical and pharmacy data for all members and includes the specific Medically Supportive Food/Meals/Medically Tailored Meals criteria to identify members.

2.2.1.2 The Population Report is provided to the AAH CS team for further processing.

2.2.1.1 Notification of Eligibility

2.2.1.2.1.1 Members are notified of Medically Supportive Food/Meals/Medically Tailored Meals eligibility via telephonic communication.

2.2.2 Referrals Based CS

2.2.3 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.2.4 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible, will then connect the Member to a CS Provider for the provision of services.

2.2.4.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.2.5 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.

2.3 Request for Medically Supportive Food/Meals/Medically Tailored Meals Services

2.3.1 AAH verifies a member's health plan eligibility.

2.3.1.1 Request is reviewed

2.3.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.3.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.3.2 Urgent request for Medically Supportive Food/Meals/Medically Tailored Meals services will follow the standard AAH timeline in accordance with UM-051, Timeliness of UM Decision Making and Notification.

2.3.3 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.3.4 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.3.5 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.3.5.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.3.5.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.3.5.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.4 Continuity of Care

2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the plan's Evidence of Coverage and Disclosure forms, and upon request, the Alliance also sends a copy of the policy to the member.

2.4.2 Upon the 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 priori Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.4.2.1 AAH offers the CS service which the member had received through their prior MCP.

2.4.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.

2.4.3 AAH will automatically authorize the CS service when the above conditions are met.

2.5 Data Sharing

2.5.1 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 authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.5.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.5.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.5.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services (DHCS) guidelines.

2.5.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.6 Eligibility

2.6.1 Individuals with chronic conditions, such as but not limited to diabetes,

cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

2.6.2 Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

2.6.3 Individuals with extensive care coordination needs.

2.7 Restrictions / Limitations

2.7.1 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.

2.7.1.1 Up to two (2) medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.

2.7.1.2 Meals that are eligible for or reimbursed by alternate programs are not eligible.

2.7.1.3 Meals are not covered to respond solely to food insecurities.

2.7.2 Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using AAH funding.

2.8 Payment

2.8.1 AAH will receive and disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.8.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.8.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.8.3.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.8.3.2 AAH will pay or deny 95% of clean claims within 45 working days of

receipt

2.8.3.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.8.4 PMPM payments will be provided for applicable CS services (e.g., housing).

2.9 Discontinuing Services

2.9.1 Discontinuing of CS services will be based on:

2.9.1.1 Goals met/completion of meal program with no extension needed

2.9.1.2 Termination of coverage

2.9.1.3 Unable to establish or maintain contact with member

2.9.1.4 No longer meets criteria

2.9.1.5 Member/caregiver declines services

2.9.1.6 Death of member

2.9.2 CS provider will notify AAH CS team if member terminates program early.

2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System at authorization expiration.

2.10 Licensing / Allowable Providers

2.10.1 CS Medically Tailored Meals/Medically Supportive Foods Providers must have experience and expertise with providing these unique services.

2.10.2 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.

2.10.3 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 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 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
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
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POLICY AND PROCEDURE

Policy Number	CM-025
Policy Name	Community Supports – Medically Supportive Food/Meals/Medically Tailored Meals
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	~~01/11/2023~~TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

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1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

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1.4.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 AAH Medically Supportive Food/Meals/Medically Tailored Meals may include:

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2.2.1 Report Based CS

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2.4.2 Upon the 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 priori Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

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2.5.1 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 authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.5.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

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2.6.1 Individuals with chronic conditions, such as but not limited to diabetes,

cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

2.6.2 Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

2.6.3 Individuals with extensive care coordination needs.

2.7 Restrictions / Limitations

2.7.1 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.

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2.7.1.3 Meals are not covered to respond solely to food insecurities.

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2.8.1 AAH will receive and disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

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2.8.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.8.3.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.8.3.2 AAH will pay or deny 95% of clean claims within 45 working days of

receipt

2.8.3.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.8.4 PMPM payments will be provided for applicable CS services (e.g., housing).

2.9 Discontinuing Services

2.9.1 Discontinuing of CS services will be based on:

2.9.1.1 Goals met/completion of meal program with no extension needed

2.9.1.2 Termination of coverage

2.9.1.3 Unable to establish or maintain contact with member

2.9.1.4 No longer meets criteria

2.9.1.5 Member/caregiver declines services

2.9.1.6 Death of member

2.9.2 CS provider will notify AAH CS team if member terminates program early.

2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System at authorization expiration.

2.10 Licensing / Allowable Providers

2.10.1 CS Medically Tailored Meals/Medically Supportive Foods Providers must have experience and expertise with providing these unique services.

2.10.2 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.

2.10.3 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 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 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
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CM-026
Policy Name	Community Supports – Recuperative Care (Medical Respite)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Recuperative Care (Medical Respite) Services for their CS clients experiencing homelessness and housing instability.

- Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

- AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.
- The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.
- The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.
- Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 At a minimum, AAH's service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

2.1.1 Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs

2.1.2 Coordination of transportation to post-discharge appointments

2.1.3 Connection to any other on-going services an individual may require including mental health and substance use disorder services

2.1.4 Support in accessing benefits and housing

2.1.5 Gaining stability with case management relationships and programs

2.2 AAH services provided to an individual while in recuperative care will not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other housing Community Supports will be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers.

2.3 AAH services provided will utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.4 Member Identification

2.4.1 Referrals Based CS

2.4.2 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.4.3 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.4.3.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.4.4 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.

2.4.5 Notification of Eligibility

2.4.5.1 AAH will notify members of Recuperative Care (Medical Respite) eligibility via telephonic communication.

2.5 Request for Recuperative Care (Medical Respite) Services

2.5.1 AAH verifies a member's health plan eligibility.

2.5.1.1 Request is reviewed

2.5.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.5.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.5.2 Urgent requests for Recuperative Care (Medical Respite) services will follow the standard AAH timeline in accordance with UM-051, Timeliness of UM Decision Making and Notification.

2.5.3 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.5.4 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.5.5 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.5.6 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative

resources.

2.5.7 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.5.8 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.6 Continuity of Care

2.6.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.6.2 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 (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.6.2.1 AAH offers the CS service which the member received through their prior MCP.

2.6.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.

2.6.3 AAH will automatically authorize the CS service when the above conditions are met.

2.7 Data Sharing

2.7.1 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 authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.7.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.7.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.7.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.7.5 AAH Collects, analyzes, and reports financial measures, health status, and other

measures and outcome data to be reported as requested or per DHCS' guidelines.

2.8 Eligibility

2.8.1 Individuals who are at risk of hospitalization or are post-hospitalization, and

2.8.2 Individuals who live alone with no formal supports; or

2.8.3 Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.

2.9 Payment

2.9.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.9.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.9.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.9.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.9.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.9.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.10 Restrictions and Limitations

2.10.1 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.

2.10.2 Recuperative care/medical respite is an allowable Community Supports service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

2.10.3 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.

2.11 Discontinuing Services

2.11.1 Discontinuing of CS services will be based on:

2.11.1.1 Goals met/improved health status

2.11.1.2 Termination of coverage

2.11.1.3 No longer meets criteria

2.11.1.4 Member/caregiver declines services

2.11.1.5 Death of member

2.11.2 CS provider will notify AAH CS team of AAH members who have discharged from Medical Respite within 1 week of discharge.

2.11.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.12 Licensing / Allowable Providers

2.12.1 AAH CS Providers must have experience and expertise with providing these unique services.

2.12.2 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.

2.12.3 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

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
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	CM-026
Policy Name	Community Supports – Recuperative Care (Medical Respite)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	~~01/11/2023~~TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Recuperative Care (Medical Respite) Services for their CS clients experiencing homelessness and housing instability.

- Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

- AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.
- The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.
- The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.
- Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 At a minimum, AAH's service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

2.1.1 Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs

2.1.2 Coordination of transportation to post-discharge appointments

2.1.3 Connection to any other on-going services an individual may require including mental health and substance use disorder services

2.1.4 Support in accessing benefits and housing

2.1.5 Gaining stability with case management relationships and programs

2.2 AAH services provided to an individual while in recuperative care will not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other housing Community Supports will be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers.

2.3 AAH services provided will utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.4 Member Identification

2.4.1 Referrals Based CS

2.4.2 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.4.3 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

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2.4.5.1 AAH will notify members of Recuperative Care (Medical Respite) eligibility via telephonic communication.

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2.5.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

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2.6.2 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 (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

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2.7.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with

additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.7.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.7.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

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2.9.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.9.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.9.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.9.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.9.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.9.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.10 Restrictions and Limitations

2.10.1 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.

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2.11 Discontinuing Services

2.11.1 Discontinuing of CS services will be based on:

2.11.1.1 Goals met/improved health status

2.11.1.2 Termination of coverage

2.11.1.3 No longer meets criteria

2.11.1.4 Member/caregiver declines services

2.11.1.5 Death of member

2.11.2 CS provider will notify AAH CS team of AAH members who have discharged from Medical Respite within 1 week of discharge.

2.11.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

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2.12.3 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

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
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controlsls

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POLICY AND PROCEDURE

Policy Number	CM-027
Policy Name	Community Supports – Oversight, Monitoring & Controls
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	TBD

POLICY STATEMENT

1.1. In order to provide Community Supports (CS) services to eligible Alameda Alliance for Health (AAH) Medi-Cal members, AAH contracts with a network of CS Providers.

1.2. AAH ensures that CS Providers comply with program requirements as outlined in CalAIM Program.

1.2.1. Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.3. AAH takes a proactive approach to ensuring authorization for CS in a medically appropriate, equitable, and non-discriminatory manner. Each interested CS provider is required to go through a pre-certification process. The pre-certification includes requesting proof of culturally-competent and linguistically-appropriate services. AAH seeks to contract with a diverse set of providers to ensure non-discrimination, specifically in the area of diverse language capacity. AAH also employs a culturally diverse staff. Once a provider has been contracted, training is provided which has cultural sensitivity practices built in. Also, non-discriminatory practices are inherent to the annual Population Needs Assessment and Population Health Management Strategy, both of which are drivers in the selection process for bringing on new CS services.

1.4. AAH monitors and evaluates the effectiveness and cost-effectiveness of the CS services.

PROCEDURE

2.1 Auditing and Oversight of CS Provider Activities

2.1.1 AAH will conduct auditing and oversight of CS Provider activities through the following:

2.1.1.1 Monthly monitoring of CS and reports;

2.1.1.2 Quarterly monitoring of AAH internal and regulatory reports; and

2.1.1.3 Annual CS Provider onsite visits and case file review appropriate to the category of CS. These visits may be done remotely, as necessary.

2.2 CS Data and Reports

2.2.1 AAH will collect and monitor CS services utilizing operational and clinical data, including data submitted from CS Providers as well as internal data.

2.2.2 Data submitted from CS Providers will be monitored for completeness and data accuracy to meet all reporting requirements set forth by AAH and DHCS.

2.2.3 AAH Analytics team will develop CS reports that will include utilization by approved, denied, and received services as well as by other categories such as CS service and provider. Additional reporting may include financial, Grievance and Appeals, and other utilization and quality metric reports.

2.2.4 In addition, AAH will produce and monitor all regulatory reporting as required by DHCS.

2.2.5 Reports will be produced on a monthly and/or quarterly basis and distributed to the appropriate teams for monitoring and review.

2.2.6 Analysis of effectiveness and cost-effectiveness of CS Services

2.2.6.1 Pre-approved CS services have been deemed cost-effective alternatives to State Plan Covered services or settings by DHCS, taking into consideration the results of the Whole Person Care (WPC) and Health Homes Pilot (HHP).

2.2.6.2 AAH will perform annual analysis of CS members to evaluate whether a CS is a cost-effective alternative to a State Plan Covered service or setting. Financial and utilization analysis of members receiving CS will be included. Industry standard metrics will be used to analyze utilization patterns and trends across care settings as well as total costs for the CS population.

2.2.6.3 Diversity and equity utilization metrics will be analyzed and compared against AAH's overall population. The outcomes of these analyses will provide information as to whether any modifications should be made to the CS service offering. Appropriate lag times will be incorporated as necessary. Should evaluation findings identify instances where service authorizations

have had an inequitable effect, a special task force, including the provider, will be convened to identify the root cause. Interventions would include re-training, enhanced outreach and network development, as needed, to focus on quality initiatives.

2.2.7 AAH's CS, Analytics and Quality teams utilize information obtained and incorporate CS data into Plan Quality Activities. AAH staff will utilize information obtained to define and drive improvement through interventions and education with targeted providers who have unique or outlying issues or identified trends.

2.3 CS Provider Onsite Visits and Case File Reviews

2.3.1 AAH CS Staff perform site visits, when possible, in order to evaluate CS operational and care management activities.

2.3.1.1 Year 1: AAH staff will perform onsite (when possible) visits at least once during the first year and more frequently if issues are identified through the quarterly reports of CS Provider activities.

2.3.1.2 Year 2 and beyond: AAH staff will perform onsite (when possible) visits annually in order to assess CS activities. Onsite visits will assess both operational and care management activities of the CS Providers.

2.3.1.3 Operational areas to be reviewed include:

- Staffing, including Case Ratios as applicable
- Reporting and tracking systems
- Program development
- Staff training

2.3.2 Case File Review: A random sample of cases , using 8/30 methodology will be reviewed for evidence of required CS Care Management services including:

2.3.2.1 Outreach and engagement

2.3.2.2 Communication between CS Care Team members and Primary Care provider

2.3.2.3 Process metrics specific to the category of CS being provided to assess compliance with regulatory, contractual and programmatic requirements.

2.3.2.4 Incorporation of Trauma Informed Care practices

2.3.3 AAH will work collaboratively with CS Providers in order to identify and address solutions and resolve any areas of deficiency.

2.3.4 If a corrective approach to deficiency cannot be agreed upon, then a formal CAP may be required.

2.3.5 If a CAP is requested and the CS Provider does not meet or is unable to meet the CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to

ensure that the CS Provider is meeting CS program delivery requirements.

DEFINITIONS / ACRONYMS

CS	Community Supports
AAH	Alameda Alliance for Health
DHCS	Department of Health Care Services
CAP	Corrective Action Plan
HEDIS	Healthcare Effectiveness Data and Information Set

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CRE-018 Credentialing and Recredentialing of Community Supports Providers

REVISION HISTORY

01/11/2023

REFERENCES

California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021

MONITORING

Monthly schedule will be established and shared with CS providers at the beginning of each year for scheduled CS Provider oversight & monitoring.

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POLICY AND PROCEDURE

Policy Number	CM-027
Policy Name	Community Supports – Oversight, Monitoring & Controls
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Approval/Revision Date	~~01/11/2023~~TBD

POLICY STATEMENT

1.1. In order to provide Community Supports (CS) services to eligible Alameda Alliance for Health (AAH) Medi-Cal members, AAH contracts with a network of CS Providers.

1.2. AAH ensures that CS Providers comply with program requirements as outlined in CalAIM Program.

1.2.1. Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.3. AAH takes a proactive approach to ensuring authorization for CS in a medically appropriate, equitable, and non-discriminatory manner. Each interested CS provider is required to go through a pre-certification process. The pre-certification includes requesting proof of culturally-competent and linguistically-appropriate services. AAH seeks to contract with a diverse set of providers to ensure non-discrimination, specifically in the area of diverse language capacity. AAH also employs a culturally diverse staff. Once a provider has been contracted, training is provided which has cultural sensitivity practices built in. Also, non-discriminatory practices are inherent to the annual Population Needs Assessment and Population Health Management Strategy, both of which are drivers in the selection process for bringing on new CS services.

1.4. AAH monitors and evaluates the effectiveness and cost-effectiveness of the CS services.

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2.1.1.2 Quarterly monitoring of AAH internal and regulatory reports; and

2.1.1.3 Annual CS Provider onsite visits and case file review appropriate to the category of CS. These visits may be done remotely, as necessary.

2.2 CS Data and Reports

2.2.1 AAH will collect and monitor CS services utilizing operational and clinical data, including data submitted from CS Providers as well as internal data.

2.2.2 Data submitted from CS Providers will be monitored for completeness and data accuracy to meet all reporting requirements set forth by AAH and DHCS.

2.2.3 AAH Analytics team will develop CS reports that will include utilization by approved, denied, and received services as well as by other categories such as CS service and provider. Additional reporting may include financial, Grievance and Appeals, and other utilization and quality metric reports.

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2.2.6.3 Diversity and equity utilization metrics will be analyzed and compared against AAH's overall population. The outcomes of these analyses will provide information as to whether any modifications should be made to the CS service offering. Appropriate lag times will be incorporated as necessary. Should evaluation findings identify instances where service authorizations

have had an inequitable effect, a special task force, including the provider, will be convened to identify the root cause. Interventions would include re-training, enhanced outreach and network development, as needed, to focus on quality initiatives.

2.2.7 AAH's CS, Analytics and Quality teams utilize information obtained and incorporate CS data into Plan Quality Activities. AAH staff will utilize information obtained to define and drive improvement through interventions and education with targeted providers who have unique or outlying issues or identified trends.

2.3 CS Provider Onsite Visits and Case File Reviews

2.3.1 AAH CS Staff perform site visits, when possible, in order to evaluate CS operational and care management activities.

2.3.1.1 Year 1: AAH staff will perform onsite (when possible) visits at least once during the first year and more frequently if issues are identified through the quarterly reports of CS Provider activities.

2.3.1.2 Year 2 and beyond: AAH staff will perform onsite (when possible) visits annually in order to assess CS activities. Onsite visits will assess both operational and care management activities of the CS Providers.

2.3.1.3 Operational areas to be reviewed include:

- Staffing, including Case Ratios as applicable
- Reporting and tracking systems
- Program development
- Staff training

2.3.2 Case File Review: A random sample of cases , using 8/30 methodology will be reviewed for evidence of required CS Care Management services including:

2.3.2.1 Outreach and engagement

2.3.2.2 Communication between CS Care Team members and Primary Care provider

2.3.2.3 Process metrics specific to the category of CS being provided to assess compliance with regulatory, contractual and programmatic requirements.

2.3.2.4 Incorporation of Trauma Informed Care practices

2.3.3 AAH will work collaboratively with CS Providers in order to identify and address solutions and resolve any areas of deficiency.

2.3.4 If a corrective approach to deficiency cannot be agreed upon, then a formal CAP may be required.

2.3.5 If a CAP is requested and the CS Provider does not meet or is unable to meet the CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to

ensure that the CS Provider is meeting CS program delivery requirements.

DEFINITIONS / ACRONYMS

CS	Community Supports
AAH	Alameda Alliance for Health
DHCS	Department of Health Care Services
CAP	Corrective Action Plan
HEDIS	Healthcare Effectiveness Data and Information Set

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CRE-018 Credentialing and Recredentialing of Community Supports Providers

REVISION HISTORY

01/11/2023

REFERENCES

California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021

MONITORING

Monthly schedule will be established and shared with CS providers at the beginning of each year for scheduled CS Provider oversight & monitoring.

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	HED-001
Policy Name	Health Education Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	Health Equity Quality Improvement Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) maintains a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion, and patient education for all members. The health education program has administrative oversight by qualified staff and establishes priorities based on population assessment and quality improvement plans. The program implements evidence-based interventions and appropriate evaluation of programs. The Alliance maintains health education policies and procedures that comply with contracts, policy letters, and accepted guidelines and standards.

PROCEDURE

1. The Population Health and Equity Director at the Alliance provides administrative oversight of the Health Education Program. It is a full-time position held by a health educator with a master's degree in public health or community health, with a specialization in health education. The Population Health and Equity Director is a member of the Health Care

Services Department and specifically is a part of the Quality Improvement team to ensure coordination and integration.

2. The Alliance provides evidence-based health education programs to all members.
   2.1. The Health Education Program aligns health education interventions for addressing health categories and topics within Population Health Management.
   2.2. The Alliance uses Population Needs Assessment (PNA) findings, HEDIS results, and other internal and external data sources, to inform its program priorities, target populations, levels of intervention, and the development of the annual work plan, including program goals and objectives.
   2.3. Health Education updates its program goals, objectives, activities, and resource needs annually.

3. The Alliance ensures the organized delivery of health education programs using education strategies and methods appropriate for members and effective in achieving behavioral change. This is accomplished through:
   3.1.1. Review of relevant literature, evidence-based interventions, and best practices
   3.1.2. Offering accredited programs
   3.1.3. Evaluating health education programs

4. The Alliance may offer non-monetary incentives for participating in incentive programs, focus groups and member surveys as authorized by W&I Code section 144.07.1 pursuant to APL 16-005.

5. Alliance health education programs and services are also reviewed through regular audits to ensure they meet the cultural and linguistic needs of members and follow health literacy standards, including sixth-grade or lower reading level.

6. Alliance health education programs and services are provided at no charge to members and are delivered by the plan directly or through agreements with organizations imbedded within member communities noted for expertise in delivering health education programs. The Alliance maintains listings of the no cost community health education program referrals available to members and promotes health education opportunities through our website and member newsletter.

7. The Alliance health education program covers the following program interventions:

7.1. **Appropriate Use of Managed Health Care Services** including preventive and primary health care services, obstetrical care, health education services and appropriate use of complementary and alternative care.

7.2. **Risk Reduction and Healthy Lifestyles** including, but not limited to programs for tobacco use and cessation; alcohol and drug use; injury prevention, nutrition and physical activity.

7.2.1. Member confidentiality regarding family planning, sexuality issues and alcohol and drug use is protected.

7.2.2. The Centers for Disease Control's Diabetes Prevention Program (DPP) for members who meet the CDC criteria for participation. See *HED-009 Diabetes Prevention Program* for details.

7.3. **Self-Care and Management of Health Conditions** including but not limited to pregnancy, asthma, diabetes, and hypertension.

7.4. **Breastfeeding promotion, education, and counseling** services to pregnant and lactating members.

7.4.1. Prenatal and postpartum mailings to all identified Alliance moms with information on the benefits of breastfeeding and referral to Women Infants and Children (WIC).

7.4.2. Eligible members are referred to WIC.

7.4.3. Coordination with community agencies and referrals to ensure that postpartum women receive breastfeeding counseling and support after delivery.

7.4.4. International Board-Certified Breastfeeding Consultants (IBCLC) are available to Alliance members by phone or for in-person visits.

8. Members may access the Alliance Health Education programs upon self-referral or provider referral. The Alliance conducts outreach to maximize members' participation in programs. Health Education staff connects members with services and programs through the following activities:

8.1. Explaining the effective use of health care services and availability of health education programs in the Member Handbook (Evidence of Coverage).

8.2. Placement of health education articles in member newsletter distributed two (2) times a year.

8.3. Maintaining a library of health education handouts covering health topics listed in Alliance program interventions above, topics that align to the Population Health Management Strategy, and topics specific to the needs of our members. Handouts are available on-line and are mailed out to members upon request. Members and providers

can mail or fax in the Wellness Request form, complete the form in the online provider portal, access the online Live Healthy Library at https://alamedaalliance.org/live-healthy/live-healthy-library/, or call Health Education to make a request. Distribution of health education materials is documented in Alliance data systems as a member's Health Education Case when not accessed online.

8.4. Maintaining contracts and relationships with community organizations that provide classes, support groups and self-management programs to Alliance members at no cost.

8.5. Responding to member inquiries to the Health Education Program with information on health education program offerings, facilitate referrals and document referral and class/program completion in Alliance data systems as a Health Education Case.

8.5.1. All referrals are documented, and class completion is documented for programs paid for by the Alliance.

8.5.2. Health Education Cases are closed after 4 months of non-activity.

8.6. Sending targeted mailings to members with specific health conditions. Mailings include health education materials, condition self-management tools and information on self-management programs and classes that are no cost to members.

9. The Alliance ensures that members receive point of services education as a part of preventive and primary health care visits. Supports for providers include:

9.1. On-line health education materials in threshold languages culturally appropriate health education resources and referrals that can be shared with members.

9.2. A provider health education listing of health referrals available to Alliance members.

9.3. *Provider Wellness Request Form* available for download or through the Alliance Provider Portal to request Alliance health education programs and materials for members.

9.4. Provider communication, training, and education regarding delivery of health education services through provider quarterly packets and Alliance website resources.

10. The Alliance ensures the availability of Community Health Workers (CHWs) for members to assist members with health care system navigation, communicating cultural and language preferences to providers, accessing health care services, educating health needs, and connecting individuals and families with community-based resources. See Alliance Policy *PH-004 Community Health Worker Services* for details.

11. The Alliance educates providers so that health education takes place at medical and non-medical key points of service contacts as part of prevention and primary health care visits. The Alliance also offers provider education and training on the PNA findings, techniques to improve provider/patient interaction, educational and staff resources, plan-specific resources

and referrals and health education requirements and monitoring. Provider training regarding health education occurs through the following methods:

11.1. Making available to provider a resource directory of health education, self-management supports, community programs and ancillary services free to members. This list is available on the provider pages of the Alliance website.
11.2. Information on accessing health education resources is included in the New Provider Orientation and Provider Manual.
11.3. Alliance website Provider section Patient Health and Wellness Education. Providers are informed of how to access website resources during their orientation and in the Provider Manual.
11.4. Informational handouts and community-based or governmental training opportunities are shared at Provider Services during periodic office visits, website postings, and/or distributed by email or fax blast.

12. The health education program conducts appropriate levels of evaluation to ensure effectiveness and monitors performance of providers that are contracted to deliver health education programs.

12.1. The health education program conducts formative, process, impact, and outcome evaluations as appropriate to ensure effectiveness and monitors the performance of providers that are contracted to deliver health education programs. Opportunities for improvement will be identified and appropriate activities implemented. The Health Education Program will be reviewed annually to ensure appropriate allocation of resources based on assessment and evaluation findings and other plan data. Health education accomplishes program evaluation through:
12.2. Utilization of a case management database and automated quarterly reports to track and monitor member requests for materials and participation in health education activities. Utilization is tracked by threshold language to ensure accessibility for Limited English Proficient (LEP) members.
12.3. Reviewing Alliance program satisfaction surveys and/or collection of survey information from contracting providers.
12.4. Monitoring of providers contracted to deliver health education services through site visits, an audit tool, and materials review. Issues of concern are addressed, and support is provided as needed to meet Alliance standards.
12.5. Collecting and analysis of data to identify change in behavior, confidence, health status or cost depending on the specific program objectives and available data.

DEFINITIONS / ACRONYMS

CDC – Centers for Disease Control and Prevention
CHW – Community Health Worker
DPP – Diabetes Prevention Program
HED – Health Education
HEDIS – Healthcare Effectiveness Data and Information Set
HIV - Human immunodeficiency virus infection
IBCLC - International Board-Certified Breastfeeding Consultants
IHA – Initial Health Appointment
LEP – Limited English Proficiency
PNA – Population Needs Assessment
WIC – Women, Infants and Children, federal nutrition program

AFFECTED DEPARTMENTS/PARTIES

Communications and Outreach
Member Services
Provider Services
Case and Disease Management

RELATED POLICIES AND PROCEDURES

HED-002 Health Education Materials
HED-009 Diabetes Prevention Program
PH-004 Community Health Worker Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Baby Steps Standard Work
HED Diabetes Prevention Program Standard Work
HED Hospital ED Asthma Referral Standard Work
HED Lactation Support Standard Work
HED Materials Standard Work
HED Member Request Standard Work
HED Programs Monitoring and Evaluation Standard Work
HED Weight Watchers Standard Work

REVISION HISTORY

11/21/2006, 1/1/2008, 12/2009, 2/26/2010, 1/24/2013, 3/26/2014, 3/31/2015, 6/16/2016, 5/25/2017, 5/3/2018, 9/6/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, 12/19/2023, TBD

REFERENCES

All Plan Letter 18-018 Diabetes Prevention Program
DHCS Contract, Exhibit A, Attachment 9, 10
MMCD Policy Letter 02-04 Health Education
MMCD Policy Letter 98-10 Breastfeeding Promotion
W&I Code section 144.07.1
Title 22, CCR, Sec. 53853 (c)

MONITORING

The Alliance annually reviews the health education policies and procedures to ensure compliance with contracts and policy letters and accepted guidelines and standards.

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POLICY AND PROCEDURE

Policy Number	HED-001
Policy Name	Health Education Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	Health Equity Quality Improvement Committee
Subcommittee Approval Date	~~11/17/2023~~TBD
Compliance Committee Approval Date	~~12/19/2023~~TBD

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AFFECTED DEPARTMENTS/PARTIES

Communications and Outreach
Member Services
Provider Services
Case and Disease Management

RELATED POLICIES AND PROCEDURES

HED-002 Health Education Materials
HED-009 Diabetes Prevention Program
PH-004 Community Health Worker Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Baby Steps Standard Work
HED Diabetes Prevention Program Standard Work
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REVISION HISTORY

11/21/2006, 1/1/2008, 12/2009, 2/26/2010, 1/24/2013, 3/26/2014, 3/31/2015, 6/16/2016, 5/25/2017, 5/3/2018, 9/6/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, 12/19/2023, TBD

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MONITORING

The Alliance annually reviews the health education policies and procedures to ensure compliance with contracts and policy letters and accepted guidelines and standards.

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POLICY AND PROCEDURE

Policy Number	HED-002
Policy Name	Health Education Materials
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal and Group Care
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

This policy concerns written health education materials that members receive from Alameda Alliance for Health (the Alliance). It applies to all members in all lines of business. The Alliance has a process for development and review of health education materials for members. The Alliance assures that materials meet required readability, suitability, accessibility, and content accuracy standards necessary to promote clear communication and understanding of health plan benefits, wellness, and disease self-management information for our diverse membership.

PROCEDURE

1. The Health Education Department uses the guide *Document A. Definitions and Requirements*, to determine which written documents are considered health education or member information materials. All Alliance member materials are reviewed by the Communications and Outreach Department. The Compliance Department reviews and submits member information documents to the Department of Health Care Services (DHCS) for approval prior to use.

2. Health education materials will be approved by a qualified health educator employed by the Alliance. The qualified health educator reviews all health education materials (plan-generated, adapted, purchased, or obtained free-of-charge) using the DHCS Readability and Suitability Checklist for Written Health Education Materials.

2.1. Newly acquired materials will be reviewed when they are procured and before distributed to members, providers, and staff.
2.2. Materials can be reviewed for readability standards and approved without completing the Readability and Suitability Checklist if they were produced by the following sources and no significant changes were made:
2.2.1. State-approved companies listed in 'Approved Companies for Written Health Education Materials' letter,
2.2.2. City, county, state, and federal government agencies, and
2.2.3. Non-profit agencies or community-based organizations when there is documentation on file that shows the material meets readability and suitability guidelines.
2.3. Materials are reviewed at least every five years or any time there are changes to health guidelines that affect the accuracy of the content.
2.4. Materials are updated as needed. Review may occur when there is a change in best practices or a regulatory board (i.e., DMHC, DHCS or CMS) mandates a change in health practices.
2.5. The Alliance maintains a signed and approved Readability and Suitability Checklist, including justification if needed, with the material and makes it available upon request to DHCS and other auditing agencies.

3. The Alliance uses the SMOG Readability Formula (Simple Measure of Gobbledygook) or comparable language assessment tool for readability analysis.
3.1. The formula is applied to the English version of all health education materials.
3.2. Materials meet a readability score of sixth grade reading level or less and are at least 12-point font.
3.3. A copy of the readability score calculation is kept with the completed Readability and Suitability Checklist.
3.4. The evaluation of readability and suitability may exclude State-mandated legal language and MCP or vendor legal disclaimers; proper nouns; defined words; phone numbers; and website addresses. Medical terminology, technical words and/or multi-syllable words that must be included in health education material and cannot be substituted for simpler words are counted once.

4. As a part of the Readability and Suitability Checklist, the qualified health educator evaluates health education materials for other readability factors such as content accuracy, use of plain language and key messages, literacy level, layout, visuals, and cultural appropriateness.

5. The Alliance's Population Health & Equity Director maintains oversight for the field-testing of all health education materials and documents the results on the Readability and Suitability Checklist.
5.1. Field-testing is optional for the following:
5.1.1. Brief updates on preventing colds and availability of seasonal flu vaccine
5.1.2. Newsletters

5.1.3. Materials developed by local county/city health departments, California state governmental organizations or the US federal government
5.1.4. Materials developed by a non-profit agency or community-based organization
5.1.5. Materials field-tested by a vendor when the qualified health educator has determined that the field-testing was conducted appropriately and with participants that represent a population similar to the targeted Alliance members
5.1.6. Materials that are from the DHCS list of approved vendors
5.1.7. Materials field-tested by another Medi-Cal Managed Care Plan
5.1.8. Material similar to another that was previously field-tested

5.2. When field-testing is not done because it is not required, the reason is documented on the Readability and Suitability Checklist.

5.3. The field-testing may include:
5.3.1. Review by the Community Advisory Committee
5.3.2. Key informant interviews with members, community informants, or internally qualified reviewers
5.3.3. Focus groups with targeted members
5.3.4. Written member or community informant surveys

6. Member health education materials containing clinical information are reviewed by the most appropriate clinical staff.
6.1. Medical accuracy is verified by the plan's nursing/pharmacy staff and/or Medical Directors. Clinical staff signs an attestation once clinical accuracy is confirmed. Attestations documented via email are acceptable.
6.2. Accuracy of content related to plan procedures, policies and applicable regulations is reviewed by plan staff whose responsibilities focus on the subject matter.

7. Health education materials may be approved by the health educator without meeting all factors on the Readability and Suitability Checklist if in the best judgment of the Health Educator, the document is appropriate for members, and the written rationale is included with the Readability and Suitability Checklist.

8. Members, family members or providers can request plan-produced educational materials in alternative formats, including Braille, accessible PDFs, large print, CD, audio, or online access by calling the Member Services Department or making a request online through the Alliance Member Portal. Alliance staff then contacts the Communications and Outreach Department who fills the request within 21 business days.
8.1. Vendor-produced materials are provided in alternate formats whenever possible, or materials of similar content are provided in alternate formats. When required, the Readability and Suitability Checklist is used to assess and approve written health education materials before conversion to an alternative format.
8.2. Members can make a standing request for an alternate format for member communications.

8.3. If providing an alternative format causes undue hardship, the Alliance will provide the information in another reasonable format, such as by phone or in-person from the plan health educator or other qualified staff (i.e., Nurse Case Manager).

9. Plan-generated informing documents and health education materials are translated into threshold languages. Upon member request, any Alliance department can request translation of member documents into non-threshold languages by submitting a request to the Communications and Outreach Department. Documents are translated according to Policy and Procedures *CRO-001 Community Relations and Outreach Activities* and *CLS-003 Language Assistance Services*.

10. The Health Education department will train and advise any Alliance department as needed regarding the readability and suitability of member documents and requirements regarding literacy level, plain language, translation, and alternative format for vision and hearing-impaired options or other disability accommodations.

11. Health education information that can be downloaded for use by members on the Alliance website is assessed and approved using the Readability and Suitability Checklist and field-tested if required. Alliance Health Education website text and linked external websites are regularly reviewed for readability and cultural appropriateness.

12. Alliance newsletters principally contain health education messages that are developed using readability and suitability guidelines.

DEFINITIONS/ACRONYMS

CMS – Centers for Medicare & Medicaid Services
DHCS – Department of Health Care Services
DMHC – California Department of Managed Health Care
Field-testing - A process through which member materials are reviewed by the target audience either through in-person review, key informant interviews, focus groups or surveys.
Health education materials – Designed to help members modify personal health behaviors, achieve, and maintain healthy lifestyles, and promote positive health outcomes by including information on health conditions, self-care, and management of health conditions. Topics may include messages about preventive care, health promotion, screenings, disease management, and healthy living.
MCP – Managed Care Plan
Member information materials – Provide members with essential information about access to and usage of Plan services. Evidence of Coverage, booklets, enrollment and disenrollment information, member rights and grievance information, new member

welcome packets, provider directories, flyers promoting a health education class, and appointment reminders are examples of informing materials.

Plain language - Plain language is clear and concise and uses short sentences and simple words. It keeps to the facts and is easy to read and to understand. Plain language is so clear, the reader can take in the writer's exact message in one reading.

Qualified health educator – A qualified health educator must have one of the following qualifications:

- Master of Public Health (MPH) degree with a specialization in health education or health promotion, from a program of study accredited by the Council on Education for Public Health, sanctioned by the American Public Health Association.
- MCHES (Master Certified Health Education Specialist) awarded by the National Commission for Health Education Credentialing, Inc.
- Training and background that is equivalent to the DHCS requirements for Health Education Consultants II/III.

SMOG - Simple Measure of Gobbledygook Readability Formula

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CLS-003 Nondiscrimination Language Assistance Services and Effective Communication for Individuals with Disabilities
C&O-001Community Relations and Outreach Activities
HED-001 Health Education Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Materials Standard Work

REVISION HISTORY

11/21/06, 1/1/2008, 12/2009, 2/26/2010, 3/28/11, 9/30/11, 3/25/2014, 5/20/2015, 6/16/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3192020, 3/18/2021, 3/17/2022, 3/21/2023, TBD

REFERENCES

CA Health and Safety Code section 1367.04(b)
DHCS Contract, Exhibit A, Attachment 9, 10, 13
DHCS All Plan Letter 18-016 Readability and Suitability of Written Health Education
DHCS APL 18-016 Materials and Attachments:

- Document A. Definitions and Requirements

- Document B. Readability
- Suitability Checklist for Written Health Education Materials)
- DHCS Approved Companies for Written Health Education Materials

MONITORING

This policy will be reviewed annually to ensure effectiveness.

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Service you can trust.

POLICY AND PROCEDURE

Policy Number	HED-002
Policy Name	Health Education Materials
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal and Group Care
Effective Date	11/21/2006
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	~~3/21/2023~~TBD

POLICY STATEMENT

This policy concerns written health education materials that members receive from Alameda Alliance for Health (the Alliance). It applies to all members in all lines of business. The ~~plan~~ Alliance has a process for development and review of health education materials for members. The ~~plan~~ Alliance assures that materials meet required readability, suitability, accessibility, and content accuracy standards necessary to promote clear communication and understanding of health plan benefits, wellness, and disease self-management information for our diverse membership.

PROCEDURE

1. The Health Education Department uses the guide *Document A. Definitions and Requirements*, to determine which written documents are considered health education or member information materials. All Alliance member materials are reviewed by the Communications and Outreach Department. The Compliance Department reviews and submits member information documents to the Department of Health Care Services (DHCS) for approval prior to use.

2. Health education materials will be approved by a qualified health educator employed by the Alliance. The qualified health educator reviews all health education materials (plan-generated, adapted, purchased, or obtained free-of-charge) using the DHCS Readability and Suitability Checklist for Written Health Education Materials.

2.1. Newly acquired materials will be reviewed when they are procured and before distributed to members, providers, and staff.
2.2. Materials can be reviewed for readability standards and approved without completing the Readability and Suitability Checklist if they were produced by the following sources and no significant changes were made:
2.2.1. State-approved companies listed in 'Approved Companies for Written Health Education Materials' letter,
2.2.2. City, county, state, and federal government agencies, and
2.2.3. Non-profit agencies or community-based organizations when there is documentation on file that shows the material meets readability and suitability guidelines.
2.3. Materials are reviewed at least every five years or any time there are changes to health guidelines that ~~effect~~affect the accuracy of the content.
2.4. Materials are updated as needed. Review may occur when there is a change in best practices or a regulatory board (i.e., DMHC, DHCS or CMS) mandates a change in health practices.
2.5. The Alliance maintains a signed and approved Readability and Suitability Checklist, including justification if needed, with the material and makes it available upon request to DHCS and other auditing agencies.

3. The Alliance uses the SMOG Readability Formula (Simple Measure of Gobbledygook) or comparable language assessment tool for readability analysis.
3.1. The formula is applied to the English version of all health education materials.
3.2. Materials meet a readability score of ~~sixth grade~~sixth grade reading level or less and are at least 12-point font.
3.3. A copy of the readability score calculation is kept with the completed Readability and Suitability Checklist.
3.4. The evaluation of readability and suitability may exclude State-mandated legal language and MCP or vendor legal disclaimers; proper nouns; defined words; phone numbers; and website addresses. Medical terminology, technical words and/or multi-syllable words that must be included in health education material and cannot be substituted for simpler words are counted once.

4. As a part of the Readability and Suitability Checklist, the qualified health educator evaluates health education materials for other readability factors such as content accuracy, use of plain language and key messages, literacy level, layout, visuals, and cultural appropriateness.

5. The Alliance's Population Health & Equity Director maintains oversight for the field-testing of all health education materials and documents the results on the Readability and Suitability Checklist.
5.1. Field-testing is optional for the following:
5.1.1. Brief updates on preventing colds and availability of seasonal flu vaccine
5.1.2. Newsletters

5.1.3. Materials developed by local county/city health departments, California state governmental organizations or the US federal government
5.1.4. Materials developed by a non-profit agency or community-based organization
5.1.5. Materials field-tested by a vendor when the qualified health educator has determined that the field-testing was conducted appropriately and with participants that represent a population similar to the targeted Alliance members
5.1.6. Materials that are from the DHCS list of approved vendors
5.1.7. Materials field-tested by another Medi-Cal Managed Care Plan
5.1.8. Material similar to another that was previously field-tested

5.2. When field-testing is not done because it is not required, the reason is documented on the Readability and Suitability Checklist.

5.3. The field-testing may include:
5.3.1. Review by the ~~Member~~ Community Advisory Committee
5.3.2. Key informant interviews with members, community informants, or internally qualified reviewers
5.3.3. Focus groups with targeted members
5.3.4. Written member or community informant surveys

6. Member health education materials containing clinical information are reviewed by the most appropriate clinical staff.
6.1. Medical accuracy is verified by the plan's nursing/pharmacy staff and/or Medical Directors. Clinical staff signs an attestation once clinical accuracy is confirmed. Attestations documented via email are acceptable.
6.2. Accuracy of content related to plan procedures, policies and applicable regulations is reviewed by plan staff whose responsibilities focus on the subject matter.

7. Health education materials may be approved by the health educator without meeting all factors on the Readability and Suitability Checklist if in the best judgment of the Health Educator, the document is appropriate for members, and the written rationale is included with the Readability and Suitability Checklist.

8. Members, family members or providers can request plan-produced educational materials in alternative formats, including Braille, accessible PDFs, large print, CD, ~~DVD,~~ audio, or online access by calling the Member Services Department or making a request online through the Alliance Member Portal. Alliance staff then contacts the Communications and Outreach Department who fills the request within 21 business days.
8.1. Vendor-produced materials are provided in alternate formats whenever possible, or materials of similar content are provided in alternate formats. When required, the Readability and Suitability Checklist is used to assess and approve written health education materials before ~~converted~~ conversion to an alternative format.
8.2. Members can make a standing request for an alternate format for member communications.

8.3. If providing an alternative format causes undue hardship, the Alliance will provide the information in another reasonable format, such as by phone or in-person from the plan health educator or other qualified staff (i.e., Nurse Case Manager).

9. Plan-generated informing documents and health education materials are translated into threshold languages. Upon member request, any Alliance department can request translation of member documents into non-threshold languages by submitting a request to the Communications and Outreach Department. Documents are translated according to Policy and Procedures *CRO-001 Community Relations and Outreach Activities* and *CLS-003 Language Assistance Services*.

10. The Health Education department will train and advise any Alliance department as needed regarding the readability and suitability of member documents and requirements regarding literacy level, plain language, translation, and alternative format for vision and hearing-impaired options or other disability accommodations.

11. Health education information that can be downloaded for use by members on the Alliance website is assessed and approved using the Readability and Suitability Checklist and field-tested if required. Alliance Health Education website text and linked external websites are regularly reviewed for readability and cultural appropriateness.

12. Alliance newsletters ~~contain principally~~principally contain health education messages that are developed using readability and suitability guidelines.

DEFINITIONS/ACRONYMS

CMS – Centers for Medicare & Medicaid Services
DHCS – Department of Health Care Services
DMHC – California Department of Managed Health Care
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AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CLS-003 Nondiscrimination Language Assistance Services and Effective Communication for Individuals with Disabilities
C&O-001Community Relations and Outreach Activities
HED-001 Health Education Program

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HED Materials Standard Work

REVISION HISTORY

11/21/06, 1/1/2008, 12/2009, 2/26/2010, 3/28/11, 9/30/11, 3/25/2014, 5/20/2015, 6/16/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3192020, 3/18/2021, 3/17/2022, 3/21/2023, TBD

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- Document B. Readability
- Suitability Checklist for Written Health Education Materials)
- DHCS Approved Companies for Written Health Education Materials

MONITORING

This policy will be reviewed annually to ensure effectiveness.

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	HED-006
Policy Name	Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal
Effective Date	6/16/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) provides Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services to members 11 years of age and older, including pregnant women who screen positively for potential alcohol misuse. This service was formerly named "Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care."

The Alliance is contractually required to provide all preventive services for members who are 21 years of age or older consistent with USPSTF Grade A and B recommendations. This policy aligns with the November 2018 and June 2020 updates to the United States Preventive Services Task Force (USPSTF) recommendations, AAP/Bright Futures and the Medi-Cal Provider Manual. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

This policy details the coverage of SABIRT services for the Alliance's Medi-Cal members and the procedures for SABIRT services. SABIRT services are provided by the member's primary care provider (PCP) to identify, reduce, and prevent problematic substance use. The Alliance does not require prior authorization for SABIRT services

and referral to substance use disorder (SUD) evaluation or treatment. See *UM-013 Coordination of Care – Substance* Use for details.

PROCEDURE

1. General requirements:

1.1. Alliance providers must provide SABIRT services for members 11 years of age and older, including pregnant women. The services may be provided by providers within their scope of practice, including but not limited to the following:

1.1.1. Licensed Physician
1.1.2. Physician Assistant
1.1.3. Nurse Practitioner
1.1.4. Certified Nurse or Licensed Midwives
1.1.5. Licensed clinical social workers
1.1.6. Licensed professional clinical counselors
1.1.7. Psychologists
1.1.8. Licensed Marriage and Family Therapists.

1.2. When providing SABIRT services, Alliance Providers must comply with all applicable laws and regulations regarding the privacy of substance use disorder (SUD) records, as well as state law concerning the right of minor over 12 years of age to consent to treatment (Title 42 CFR 2.1; 2.14; Family Code Section 6929).

1.3. If a provider is unable to provide SABIRT, the PCP refers the Member to a provider who can provide SABIRT services. The referral and subsequent treatment do not require prior authorization.

2. Screening Services

2.1 Unhealthy alcohol and drug use screening must be conducted using validated screening tools, including but are not limited to:

2.1.1. Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
2.1.2. Tobacco Alcohol, Prescription medication and other Substances (TAPS)
2.1.3. National Institute on Drug Abuse (NIDA) Quick Screen for adults
2.1.4. The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening
2.1.5. Drug Abuse Screening Test (DAST-10)
2.1.6. Alcohol Use Disorders Identification Test (AUDIT-C)
2.1.7. Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
2.1.8. Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
2.1.9. Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

3. Brief Assessment

3.1. When the screening is positive, Alliance providers use validated assessment tools to determine if unhealthy alcohol use or SUD is present. Validated assessment tools

may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

3.1.1. NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
3.1.2. Drug Abuse Screening Test (DAST-20)
3.1.3. Alcohol Use Disorders Identification Test (AUDIT)

4. Brief Interventions and Referral to Treatment

4.1. For patients with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Brief interventions will include the following:
4.1.1. Providing feedback to the patient regarding screening and assessment results;
4.1.2. Discussing negative consequences that have occurred and the overall severity of the problem;
4.1.3. Supporting the patient in making behavioral changes; and
4.1.4. Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

4.2. If brief assessment demonstrates probable AUD or SUD, providers will offer appropriate referrals to Alameda County Behavioral Health (ACBH) or outpatient heroin detoxification providers available through Medi-Cal fee-for-service program for additional evaluation and treatment, including medications for addiction treatment.
4.2.1. Providers refer directly to ACBH or to the Alliance Behavioral Health Department for screening and referral to AUD or SUD treatment services.
4.2.2. Alliance case management team may also offer appropriate referrals to members for AUD or SUD treatment services.
4.2.3. SUD referrals and subsequent treatment do not require prior authorization.

4.3. The Alliance assists members in locating available treatment services sites, including pursuit of placement outside the area if no slots are available in county. If a medically necessary appointment is unavailable in a timely fashion, the Alliance Utilization Department will approve out-of-network services.

4.4. The Alliance covers and ensures the provision of primary care and other services unrelated to alcohol and SUD treatment and coordinates services between Primary Care Providers and treatment programs. Alliance providers are informed in the Provider Manual of their responsibility for appropriate care coordination, including care coordination for behavioral health care.

4.5. Providers will make good faith efforts to confirm whether members receive referred treatment and document when, where, and any next steps following treatment. If no treatment was received, providers will follow up with the member to understand barriers and make any needed changes to the referrals. When needed, the provider will facilitate a warm hand off to treatment.

5. Documentation Requirements

5.1. Member medical records must include the following:
5.1.1. The service provided (e.g., screen and brief intervention);
5.1.2. The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);

5.1.3. The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and
5.1.4. If and where a referral to an AUD or SUD program was made.

5.2. The Alliance Quality Improvement Department will ensure provider compliance with SABIRT requirements through the Medical Record Review process (see QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)).
5.3. When members transfer from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services.
5.4. The Alliance will inform members of SABIRT services through the Alliance Member Handbook.

DEFINITIONS / ACRONYMS

4Ps - Parents, Partner, Past and Present for pregnant women and adolescents
ACBH – Alameda County Behavioral Health
AUD – Alcohol Use Disorder is the recurring use of alcohol to the point that it interferes with the user's responsibilities and/or physical health.
AUDIT - Alcohol Use Disorders Identification Test
CAGE-AID - Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs
CRAFFT - Car, Relax, Alone, Forget, Friends, Trouble for non-pregnant adolescents
DAST – Drug Abuse Screening Test
FSR – Facility Site Review
MAST-G - Michigan Alcoholism Screening Test Geriatric
MRR – Medical Record Review
NIDA - National Institute on Drug Abuse
NM-ASSIST - NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test
PARS – Physical Accessibility Review Surveys
PCP – Primary Care Provider
SABIRT – Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
SUD – Substance Use Disorder is the recurring use of a substance (legal or illegal) to the point that it interferes with the user's responsibilities and/or physical health.
TAPS - Tobacco Alcohol, Prescription medication and other Substances
Unhealthy Alcohol Use - A spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence)
Unhealthy Drug Use - The use of illegally obtained substances, excluding alcohol and tobacco products, or the nonmedical use of prescription psychoactive medications.
USPSTF – United States Preventive Services Task Force

AFFECTED DEPARTMENTS/PARTIES

Claims/Operations
Compliance

RELATED POLICIES AND PROCEDURES

QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
UM-013 Coordination of Care – Substance Abuse

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

6/16/2016, 5/25/2017, 1/04/2018, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 6/28/2022, 3/21/2023, TBD

REFERENCES

DHCS All Plan Letter 21-014 - Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
Family Code - Section 6929
Title 42 Code of Federal Regulations - Section 2.1 et seq., 2.14
USPSTF – November 2018 and June 2020 updates re: alcohol and drug use

MONITORING

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

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	HED-006
Policy Name	Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal
Effective Date	6/16/2016
Subcommittee Name	Quality Improvement Health Equity ~~Health Care Quality~~ Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	~~3/21/2023~~TBD

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This policy details the coverage of SABIRT services for the Alliance's Medi-Cal members and the procedures for SABIRT services. SABIRT services are provided by the member's primary care provider (PCP) to identify, reduce, and prevent problematic

substance use. The Alliance does not require prior authorization for SABIRT services and referral to substance use disorder (SUD) evaluation or treatment. See *UM-013 Coordination of Care – Substance* Use for details.

PROCEDURE

1. General requirements:

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1.2. When providing SABIRT services, Alliance Providers must comply with all applicable laws and regulations regarding the privacy of substance use disorder (SUD) records, as well as state law concerning the right of minor over 12 years of age to consent to treatment (Title 42 CFR 2.1; 2.14; Family Code Section 6929).

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TAPS - Tobacco Alcohol, Prescription medication and other Substances
Unhealthy Alcohol Use - A spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence)
Unhealthy Drug Use - The use of illegally obtained substances, excluding alcohol and tobacco products, or the nonmedical use of prescription psychoactive medications.
USPSTF – United States Preventive Services Task Force

AFFECTED DEPARTMENTS/PARTIES

Claims/Operations
Compliance

RELATED POLICIES AND PROCEDURES

QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
UM-013 Coordination of Care – Substance Abuse

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

6/16/2016, 5/25/2017, 1/04/2018, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 6/28/2022, 3/21/2023, TBD

REFERENCES

DHCS All Plan Letter 21-014 - Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
Family Code - Section 6929
Title 42 Code of Federal Regulations - Section 2.1 et seq., 2.14
USPSTF – November 2018 and June 2020 updates re: alcohol and drug use

MONITORING

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

ALAMEDA Alliance FOR HEALTH
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POLICY AND PROCEDURE

Policy Number	HED-007
Policy Name	Tobacco Cessation
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal
Effective Date	6/16/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) recognizes the role of Comprehensive Tobacco Cessation Services in disease prevention and the health of its membership. Therefore, the Alliance provides tobacco cessation services, coverage of cessation medications, counseling, anticipatory guidance, provider training and monitoring activities to support its members in their tobacco cessation efforts.

PROCEDURE

The Alliance implements and covers payment for the following tobacco cessation services:

1. The Alliance requires its providers to conduct initial and annual assessment of tobacco use for each adolescent and adult member to identify all members (of any age) who use tobacco products and note use in the member's medical record. The Alliance requires providers to document the following to track all tobacco use.
   1.1. Providers must complete the Individual Health Appointment (IHA) which includes review of the social history of the member which includes tobacco use (See Alliance policy and procedure *QI-124 IHA*).
   1.2. Providers must annually assess tobacco use status for every member.

1.3. Providers must ask tobacco users about their current tobacco use at every visit.
1.4. Provider Services informs primary care providers of the requirements regarding assessment of tobacco use during the New Provider Orientation and yearly thereafter in provider office visits.
1.5. Tobacco user identification will be reviewed during their routine facility site review to confirm compliance. (Reference: QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS).

2. Medi-Cal will provide coverage of prescription and Over-The-Counter (OTC) smoking/tobacco cessation covered outpatient drugs as recommended in "Treating Tobacco Use and Dependence: 2008 Update" published by the U.S. Public Health Service in May 2008 or any subsequent modification of such guideline.
   2.1. Although the Patient Protection and Affordable Care Act (ACA) Section 4107 authorizes coverage of counseling and pharmacotherapy for tobacco cessation for pregnant women, the U.S. Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women. Providers refer to the tobacco cessation guidelines by the American College of Obstetricians and Gynecologists (ACOG) before prescribing tobacco cessation medications during pregnancy.

3. Prescription and OTC smoking/tobacco cessation products are covered via the Medi-Cal Rx Contract Drugs List (CDL), https://medi-calrx.dhcs.ca.gov/home/cdl/.
   3.1. Quantity limits and other restrictions for the medications are also available in the CDL.
   3.2. Providers will need to ensure they can submit prior authorization (PAs) for any drug that will require authorization from Medi-Cal Rx. Here are the different ways that providers can register or submit a PA:
      3.2.1. **Medi-Cal Rx Secure Portal:** The prior authorization (PA) system information and forms are available on the Medi-Cal Rx website at **www.medi-calrx.dhcs.ca.gov**. Providers can check the status of requests on Medi-Cal Rx Provider Portal or by phone by calling the Medi-Cal Rx Call Center Line toll-free at **1.800.977.2273**. Please refer to **www.medi-calrx.dhcs.ca.gov**.
      3.2.2. **CoverMyMeds:** Providers can create an account and log in to submit a PA on the CoverMyMeds website at **www.covermymeds.com**. If you currently use CoverMyMeds, you can continue to utilize this platform to submit a PA. A link to CoverMyMeds can also be found in the Medi-Cal Rx Secure Portal. ***Please prioritize this submission process to minimize delays.**
      3.2.3. **NCPDP P4:** To view the Prior Authorization Request Only (P4) Payer Sheet Template, please visit **medi-calrx.dhcs.ca.gov/provider/forms**.
      3.2.4. **By Fax**: PA requests and attachments can be faxed to **1.800.869.4325**.

3.2.5. **By mail:** PA requests and attachments can be mailed to: Medi-Cal Rx Customer Service Center; Attn: PA Request; P.O. Box 730; Sacramento, CA 95741-0730.

3.3. The Alliance covers reimbursement for pharmacist professional services for furnishing nicotine replacement as required by Assembly Bill (AB) 1114 (Chapter 602, Statutes of 2016) in a community-based outpatient pharmacy setting.

3.4. The Alliance covers processing and payment of all pharmacists' professional services for furnishing nicotine replacement as allowed by AB 1114 that are billed on medical and institutional claims.

4. The Alliance provides individual, group, and telephone counseling for members of any age who use tobacco products and who wish to quit smoking.
   4.1. Providers receive codes they can use for reimbursement in their New Provider Orientation and regularly thereafter. The Alliance covers four counseling sessions of at least 10 minutes in duration and coveredat least two separate quit attempts per year without prior authorization.
   4.2. The Alliance encourages providers to use the "5 A's" model (see https://www.ahrq.gov/prevention/guidelines/tobacco/5steps.html) or other validated behavior change models when counseling patients.
   4.3. The Alliance ensures that providers refer members to Kick It California or the Asian Smokers' Quitline.
   4.4. Providers may refer members or members can self-refer to Alliance sponsored tobacco cessation group classes or telephone counseling through Kick It California or the Asian Smokers' Quitline.
      4.4.1. The Alliance maintains a list of available tobacco cessation services and collaborates with the local county tobacco control program.
      4.4.2. Members and providers connect with the programs through the Alliance Wellness Request Form, by calling Alliance Health Programs, or through referral from their provider or Alliance Case Management staff.
      4.4.3. The Alliance also participates in Kick It California's Web-referral option.
   4.5. All individual, group and telephone counseling options are free to Alliance members.

5. The Alliance provides services for pregnant tobacco users. At a minimum, providers:
   5.1. Ask all pregnant women if they use tobacco or are exposed to tobacco smoke and advise them to stop using tobacco.
   5.2. Offer all pregnant smokers during pregnancy at least one face-to-face counseling session per quit attempt. The counseling services will be covered for 60 days after delivery plus any additional days up to the end of the month.
   5.3. Refer pregnant women to a tobacco cessation quit line.
   5.4. Refer to the American College of Obstetrics and Gynecology (ACOG) Guidelines before considering offering tobacco cessation medication during pregnancy.

6. The Alliance PCPs provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

6.1. The Alliance covers medically necessary tobacco cessation services, both counseling and medications for children up to age 21 in compliance with Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.
6.2. Services will be provided in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance, as periodically updated.

7. The Alliance informs and educates clinicians on to effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant women and where to find on-line courses.
   7.1. The Provider Services Department conducts provider training on tobacco cessation services. (Reference: PR-001 – New Provider Orientation)
   7.2. As required in our Department of Health Care Services (DHCS) contracts, provider training includes:
      7.2.1. Any new requirements for comprehensive tobacco cessation member services including Policy Letter 16-014, or superseding APL or Contract Amendment;
      7.2.2. The overview of the "Treating Tobacco Use and Dependence: 2008 Update;"
      7.2.3. How to use and adopt the "5 A's" for treating tobacco use and dependence in the provider's clinic practice;
      7.2.4. Requirements for pregnant tobacco users;
      7.2.5. Requirements regarding preventing tobacco use in children and adolescents, and
      7.2.6. Available online courses in tobacco cessation.
   7.3. Provider training links are available on the AAH website. Tobacco related training opportunities are shared with providers as available.

8. The Alliance will ensure that our primary care practices institute a tobacco user identification system per USPSTF recommendations. Reports on tobacco use are used to coordinate members' tobacco cessation interventions.
   8.1. The Alliance annually reviews a report on Alliance tobacco users that combines Nicotine Replacement Therapy (NRT) claims, health risk assessment results, case management data and ICD-10 codes for nicotine dependence.
   8.2. Summary reports are reviewed at the Internal Quality Improvement Committee and reported to the Health Care Quality Committee.

9. Tracking Treatment Utilization of Tobacco Users
   9.1. The Alliance maintains a system to track utilization of tobacco cessation interventions. Utilization is tracked through NRT pharmacy claims, aggregate reports from Kick It California, Alliance smoking cessation class referrals, and CAHPS survey results.
   9.2. Summary reports are reviewed at least annually at the AAH's Internal Quality Improvement Committee and reported to the Quality Improvement Health Equity Committee.

10. The tobacco use and treatment utilization results are used to guide plan and provider screening and cessation interventions and track prevalence over time.

DEFINITIONS / ACRONYMS

5 A's – Ask, Advise, Assess, Assist, and Arrange
AAH – Alameda Alliance for Health
ACA – Affordable Care Act
ACOG - American College of Obstetricians and Gynecologists
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CDL – Medi-Cal Rx Contracted Drugs List
DHCS – Department of Health Care Services
EPSDT - Early and Periodic Screening, Diagnosis and Treatment
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OTC – Over-The-Counter
PA – Prior Authorization
PARS – Physical Accessibility Review Surveys
PCP – Primary Care Physician
USPHS – United State Public Health Service
USPSTF – United States Preventive Services Task Force

AFFECTED DEPARTMENTS/PARTIES

Compliance
Pharmacy
Provider Services
Quality Improvement
Utilization Management

RELATED POLICIES AND PROCEDURES

UM-018 Targeted Case Management (TCM) and EPSDT Supplemental
PR-001 New Provider Orientation
QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS)
QI-124 Individual Health Appointment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Tobacco Strategy Standard Work

REVISION HISTORY

6/16/2016, 5/25/2017, 1/4/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, TBD

REFERENCES

- American College of Obstetrics and Gynecology, Tobacco Cessation Guidelines
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- Medi-Cal Rx Provider Manual
- U.S. Public Health Service, Treating Tobacco Use and Dependence: 2008 Update
- Assembly Bill (AB) 1114 (Chapter 602, Statutes of 2016

MONITORING

The Quality Improvement Department will review the policy annually for compliance with regulatory and contractual requirements.

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	HED-007
Policy Name	Tobacco Cessation
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal
Effective Date	6/16/2016
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	~~3/21/2023~~TBD

POLICY STATEMENT

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PROCEDURE

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7.2.6. Available online courses in tobacco cessation.
7.3. Provider training links are available on the AAH website. Tobacco related training opportunities are shared with providers as available.

8. The Alliance will ensure that our primary care practices institute a tobacco user identification system per USPSTF recommendations. Reports on tobacco use are used to coordinate members' tobacco cessation interventions.
8.1. The Alliance annually reviews a report on Alliance tobacco users that combines Nicotine Replacement Therapy (NRT) claims, health risk assessment results, case management data and ICD-10 codes for nicotine dependence.
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9.2. Summary reports are reviewed at least annually at the AAH's Internal Quality Improvement Committee and reported to the ~~Health Care Quality~~Quality Improvement Health Equity Committee.

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DEFINITIONS / ACRONYMS

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MRR – Medical Record Review
NRT – Nicotine Replacement Therapy
OTC – Over-The-Counter
PA – Prior Authorization
PARS – Physical Accessibility Review Surveys
PCP – Primary Care Physician
~~**SHA** – Staying Healthy Assessment~~
USPHS – United State Public Health Service
USPSTF – United States Preventive Services Task Force

AFFECTED DEPARTMENTS/PARTIES

Compliance
Pharmacy
Provider Services
Quality Improvement
Utilization Management

RELATED POLICIES AND PROCEDURES

UM-018 Targeted Case Management (TCM) and EPSDT Supplemental
PR-001 New Provider Orientation
QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS)
QI-124 Individual Health Appointment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Tobacco Strategy Standard Work

REVISION HISTORY

6/16/2016, 5/25/2017, 1/4/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, TBD

REFERENCES

- American College of Obstetrics and Gynecology, Tobacco Cessation Guidelines
- Department of Health Care Services (DHCS) All Plan Letter 16-014 Tobacco Cessation
- DHCS All Plan Letter 22-012 Governor's Executive Order N-01-19, regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
- DMHC APL 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx
- Medi-Cal Rx Provider Manual
- U.S. Public Health Service, Treating Tobacco Use and Dependence: 2008 Update
- Assembly Bill (AB) 1114 (Chapter 602, Statutes of 2016

MONITORING

The Quality Improvement Department will review the policy annually for compliance with regulatory and contractual requirements.

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	HED-009
Policy Name	Diabetes Prevention Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal
Effective Date	5/16/2019
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

In accordance with APL 18-018 Alameda Alliance for Health (The Alliance) covers the Diabetes Prevention Program (DPP) benefit to eligible members. DPP programs are a part of the Alliance' Basic Population Health Management strategies. Members at risk for diabetes who participate in DPP programs learn to make healthy lifestyle choices that reduce their risk of diabetes.

PROCEDURE

1. The Alliance contracts with DPP provider(s) who deliver direct services to members through sessions taught by peer coaches. The Alliance ensures that the DPP providers comply with the most current Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) guidelines and obtain pending, preliminary, or full CDC recognition.

   Our contracted DPP providers use a CDC-approved lifestyle change curriculum that does all of the following:

   1.1. Emphasizes self-monitoring, self-efficacy, and problem solving,
   1.2. Provides for coach feedback,
   1.3. Includes participant materials to support program goals, and

1.4. Requires participant weigh-ins to track and achieve program goals.

2. DPP sessions are taught by peer coaches, also known as lifestyle coaches, who promote realistic lifestyle changes, emphasize weight loss through healthy eating and physical activity, and implement the DPP curriculum.

3. Members must meet the most current CDC DPRP participant eligibility requirements to qualify for the DPP benefit.

4. The Alliance covers a minimum of 22 DPP sessions for the first 12 months of the DPP benefit. Months one (1) through 12, known as the core services period, consist of weekly core sessions in the first six (6) months followed by monthly core maintenance sessions in the next six (6) months. Thereafter, the Alliance will provide 12 months of ongoing maintenance sessions to qualified members to promote continuous healthy behaviors.

   4.1. A member will qualify for the ongoing maintenance sessions if:
      4.1.1. The member achieves and/or maintains minimum weight loss of five percent for the first core session, and
      4.1.2. The member meets the attendance requirement, as outlined in the Medi-Cal Provider Manual.
   4.2. The Alliance accepts the below modalities for the required weigh-ins:
      4.2.1. In-person weigh-in at a DPP session or DPP provider location;
      4.2.2. A remote weigh-in at the member's home using scales with digital or Bluetooth communications capability; or
      4.2.3. Self-reported weigh-ins with or without confirmatory documentation.

5. The Alliance will cover the following delivery methods for DPP sessions as deemed clinically appropriate:

   5.1. In-Person,
   5.2. Distance Learning,
   5.3. Online, or
   5.4. Combination – Combination refers to any combination of in-person, distance learning, or online delivery methods.

6. The benefit will be offered as often as necessary, but the member's medical record must indicate that the member's medical condition or circumstance warrants repeat or additional participation in the DPP benefit.

   The Alliance will use the below circumstances when identifying members who warrant repeat or additional participation:
   6.1. Member switched enrollment from one MCP to a different MCP,
   6.2. Member transitioned from Fee-for-Service Medi-Cal into an MCP,
   6.3. Member moved to a different county,
   6.4. Member experienced a lapse in Medi-Cal enrollment, and
   6.5. Member has, or had, medical conditions that hinder DPP session attendance.

7. The Alliance will ensure that DPP providers use a CDC-approved curriculum. DPP providers may use either the official CDC curriculum or a modified curriculum that has been approved by the CDC.

8. The Alliance will ensure that DPP services are provided in a culturally and linguistically appropriate manner. All translated curriculum materials will be made available to members timely and meet all applicable requirements.

9. The Alliance will maintain documentation of appropriate codes for all DPP services.

DEFINITIONS / ACRONYMS

CDC – Centers for Disease Control and Prevention
DPP, Diabetes Prevention Program - an evidence-based lifestyle change program, taught by peer coaches, designed to prevent, or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes.
DPRP - Diabetes Prevention Recognition Program
Peer Coach - a physician, non-physician practitioner, or an unlicensed person who is trained to deliver the required curriculum content and who possesses the skills, knowledge, and qualities specified in the most current CDC DPRP guidelines.
In-Person Delivery - For in-person delivery, members are physically present in a classroom or classroom-like setting with a peer coach.
Distance Learning Delivery - Distance learning occurs when peer coaches deliver sessions via remote classroom or telehealth. The peer coach is present in one location while participants call in or participate by videoconference from another location.
Online Delivery - Online delivery can be conducted either through synchronous real-time interactive audio and video telehealth communication or through asynchronous store and forward telehealth communication. Members can log into DPP sessions via a computer, laptop, tablet, mobile phone, or other device from any location, such as the member's home, without a practitioner or coach present. In addition, members must interact with peer coaches at various times and by various communication methods, including but not limited to online classes, emails, phone calls, or texts.

AFFECTED DEPARTMENTS/PARTIES

Member Services
Quality Improvement

RELATED POLICIES AND PROCEDURES

HED-001 Health Education Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Diabetes Prevention Program (DPP) Standard Work

REVISION HISTORY

5/16/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, TBD

REFERENCES

- CDC-approved curriculum
- Code of Federal Regulations (CFR) Title 45, Part 92
- DHCS All Plan Letter 18-018 Diabetes Prevention Program
- Patient Protection and Affordable Care Act §1557 (42 United States Code (USC) §18116)
- WIC Section 14029.91

MONITORING

The Alliance will ensure compliance of providing the DPP benefit through monitoring of our contracted DPP providers. Monitoring will include tracking and trending of grievances and appeals that are filed against our contracted provider(s).

ALAMEDA Alliance FOR HEALTH
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POLICY AND PROCEDURE

Policy Number	HED-009
Policy Name	Diabetes Prevention Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal
Effective Date	5/16/2019
Subcommittee Name	~~Health Care Quality~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	~~3/21/2023~~TBD

POLICY STATEMENT

In accordance with APL 18-018 Alameda Alliance for Health (~~"~~The Alliance~~"~~) covers the Diabetes Prevention Program (~~"~~DPP~~"~~) benefit to eligible members. DPP programs are a part of the Alliance' Basic Population Health Management strategies. Members at risk for diabetes who participate in DPP programs learn to make healthy lifestyle choices that reduce their risk of diabetes.

PROCEDURE

1. The Alliance contracts with DPP provider(s) who deliver direct services to members through sessions taught by peer coaches. The Alliance ensures that the DPP providers comply with the most current Centers for Disease Control and Prevention (~~"~~CDC~~"~~) Diabetes Prevention Recognition Program (~~"~~DPRP~~"~~) guidelines and obtain pending, preliminary, or full CDC recognition.

   Our contracted DPP providers use a CDC-approved lifestyle change curriculum that does all of the following:

   1.1. Emphasizes self-monitoring, self-efficacy, and problem solving,
   1.2. Provides for coach feedback,

1.3. Includes participant materials to support program goals, and
1.4. Requires participant weigh-ins to track and achieve program goals.

2. DPP sessions are taught by peer coaches, also known as lifestyle coaches, who promote realistic lifestyle changes, emphasize weight loss through healthy eating and physical activity, and implement the DPP curriculum.

3. Members must meet the most current CDC DPRP participant eligibility requirements to qualify for the DPP benefit.

4. The Alliance covers a minimum of 22 DPP sessions for the first 12 months of the DPP benefit. Months one (1) through 12, known as the core services period, consist of weekly core sessions in the first six (6) months followed by monthly core maintenance sessions in the next six (6) months. Thereafter, the Alliance will provide 12 months of ongoing maintenance sessions to qualified members to promote ~~continues~~ continuous healthy behaviors.

   4.1. A member will qualify for the ongoing maintenance sessions if:
      4.1.1. The member achieves and/or maintains minimum weight loss of five percent for the first core session, and
      4.1.2. The member meets the attendance requirement, as outlined in the Medi-Cal Provider Manual.
   4.2. The Alliance accepts the below modalities for the required weigh-ins:
      4.2.1. In-person weigh-in at a DPP session or DPP provider location;
      4.2.2. A remote weigh-in at the member's home using scales with digital or Bluetooth communications capability; or
      4.2.3. Self-reported weigh-ins with or without confirmatory documentation.

5. The Alliance will cover the following delivery methods for DPP sessions as deemed clinically appropriate:

   5.1. In-Person,
   5.2. Distance Learning,
   5.3. Online, or
   5.4. Combination – Combination refers to any combination of in-person, distance learning, or online delivery methods.

6. The benefit will be offered as often as necessary, but the member's medical record must indicate that the member's medical condition or circumstance warrants repeat or additional participation in the DPP benefit.

   The Alliance will use the below circumstances when identifying members who warrant repeat or additional participation:
   6.1. Member switched enrollment from one MCP to a different MCP,
   6.2. Member transitioned from Fee-for-Service Medi-Cal into an MCP,
   6.3. Member moved to a different county,
   6.4. Member experienced a lapse in Medi-Cal enrollment, and
   6.5. Member has, or had, medical conditions that hinder DPP session attendance.

7. The Alliance will ensure that DPP providers use a CDC-approved curriculum. DPP providers may use either the official CDC curriculum or a modified curriculum that has been approved by the CDC.

8. The Alliance will ensure that DPP services are provided in a culturally and linguistically appropriate manner. All translated curriculum materials will be made available to members timely and meet all applicable requirements.

9. The Alliance will maintain documentation of appropriate codes for all DPP services.

DEFINITIONS / ACRONYMS

CDC – Centers for Disease Control and Prevention
DPP, Diabetes Prevention Program - an evidence-based lifestyle change program, taught by peer coaches, designed to prevent, or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes.
DPRP - Diabetes Prevention Recognition Program
Peer Coach - a physician, non-physician practitioner, or an unlicensed person who is trained to deliver the required curriculum content and who possesses the skills, knowledge, and qualities specified in the most current CDC DPRP guidelines.
In-Person Delivery - For in-person delivery, members are physically present in a classroom or classroom-like setting with a peer coach.
Distance Learning Delivery - Distance learning occurs when peer coaches deliver sessions via remote classroom or telehealth. The peer coach is present in one location while participants call in or participate by videoconference from another location.
Online Delivery - Online delivery can be conducted either through synchronous real-time interactive audio and video telehealth communication or through asynchronous store and forward telehealth communication. Members can log into DPP sessions via a computer, laptop, tablet, mobile phone, or other device from any location, such as the member's home, without a practitioner or coach present. In addition, members must interact with peer coaches at various times and by various communication methods, including but not limited to online classes, emails, phone calls, or texts.

AFFECTED DEPARTMENTS/PARTIES

Member Services
Quality Improvement

RELATED POLICIES AND PROCEDURES

HED-001 Health Education Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Diabetes Prevention Program (DPP) Standard Work

REVISION HISTORY

5/16/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, TBD

REFERENCES

- CDC-approved curriculum
- Code of Federal Regulations (CFR) Title 45, Part 92
- DHCS All Plan Letter 18-018 Diabetes Prevention Program
- Patient Protection and Affordable Care Act §1557 (42 United States Code (USC) §18116)
- WIC Section 14029.91

MONITORING

The Alliance will ensure compliance of providing the DPP benefit through monitoring of our contracted DPP providers. Monitoring will include tracking and trending of grievances and appeals that are filed against ~~are~~ our contracted provider(s).

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	Manager, Long Term Care
Line(s) of Business	MediCal
Effective Date	01/01/2023
Approval/Revision Date	~~02/21/2023~~TBD

POLICY STATEMENT

1. This policy governs the policy and practices for providing Long Term Care (LTC) services in the following settings:
    a. LTC Nursing Facilities (NF)
    b. Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD)
    c. Subacute (SA) care facilities
    d. Pediatric Subacute (PSA) care facilities.
2. The Alliance shall authorize utilization of ~~nursing facility (NF)~~LTC facilities and services for their ~~beneficiaries~~Members when medically necessary. AAH will cover all Medically Necessary services for Members residing in or obtaining care in a NF/ICF-DD/SA/PSA Facility, including facility services, professional services, and ancillary services such as therapy (physical, occupational, speech therapy). AAH will also provide the appropriate level of care coordination, including for carved-out Medi-Cal services, as outlined in APLs and in adherence to contractual requirements and the DHCS PHM Policy Guide
3. AAH Members will 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.

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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. Effective January 1, 2024, institutional LTC Members receiving institutional LTC services in a Subacute Care Facility (SA or PSA,) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) will be enrolled in AAH. The Alliance shall authorize utilization of ICF-DD/SA/PSA services for their Members when medically necessary.
5. **Intermediate Care Services** 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 service system. Members who:
   - Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care.
   - Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.
   - Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.
6. 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:
   - 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.
   - 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.
   - 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.

   ~~1.~~a.
7. 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

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and leisure, the pursuit of their own personal future, and program planning and implementation.

8. **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.
9. **Pediatric subacute care** is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function

~~2.~~10. 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. AAH will adhere to the timeliness of authorization requirements applicable to each category of LTSS facilities.

11. Network: The Alliance endeavors to contract~~s~~ with all NF/ICF-DD/SA/PSA providers in its service area and shall comply with all applicable CMS and DHCS requirements established under Welfare and Institutions Code (W&I) Section 14186.3(c)(5), in order to ensure timely access. For Pediatric Subacute Facilities, (PSAs,) AAH will attempt to contract with all PSA facilities statewide. For SA/PSA Facilities, AAH will assure that the facility has a Subacute Care Contract with DHCS' SCU or are actively in the process of applying for a Medi-Cal Subacute Care Contract and are enrolled in Medi-Cal.
    a. Effective January 1, 2024, AAH will have and maintain an adequate network consisting of ICF/DD Homes, ICF/DD-H Homes, and ICF/DD-N Homes and SA/PSA facilities licensed and certified by the California Department of Public Health (CDPH.) The Network will include at minimum one (1) of each ICF/DD Home type within California, prioritizing ICF/DD Homes in Alameda county when available.
    b. AAH will develop sufficient Network capacity to enable timely Member placement in NF/ICF-DD/SA/PSA facilities within 5 business days of a request, as outlined in Welfare and Institutions Code (WIC) section 14197.[1] A Letter of Agreement does not constitute a Network Provider Agreement
    c. AAH will streamline credentialing and recredentialing processes for ICF-DD Home/SA/PSAs using materials submitted by ICF-DD Home/SA/PSAs to CDPH, DDS, and DHCS.
    d. AAH will also make every effort to assess the various provider types currently serving ICF-DD Home/SA/PSA residents receiving Medi-Cal covered services and maintain an adequate network with them. AAH will make every effort to contract with the providers serving Members to ensure care is not disrupted. If all efforts to contract with providers currently working with Members have been exhausted, AAH will offer the Member a choice of a network provider to transition services. AAH will ensure that the network providers are equipped and appropriately trained to work with individuals with intellectual and developmental disabilities.

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[1] State law is searchable at: https://leginfo.legislature.ca.gov/

e. AAH ensures that network providers have appropriate training on benefits coordination, including the prohibition on balance billing.
f. AAH will ensure contracted ICF-DD Home/SA/PSA Providers receive a preapproval or assessment of suitability from CDPH prior to the execution of a Network Provider Agreement for ICF-DD Home/SA/PSA Providers undergoing a change of ownership. AAHs' Network Provider Agreements with ICF-DD Home/SA/PSA Providers will have a clause stating ICF-DD Home/SA/PSA Providers will notify AAH whether it is undergoing a change of ownership so the ICF-DD Home/SA/PSA can obtain preapproval or assessment of suitability from CDPH.
g. Per APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations, or any superseding APL, AAH will comply with requirements relating to CDPH initiated facility de-certifications and licensure suspensions. To ensure Members' health and safety, AAH will work with Regional Center to coordinate care and if necessary, work jointly to transition Members appropriately.
h. AAH is responsible for ensuring that any Subcontractors and network providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs. These requirements are communicated by AAH to all Subcontractors and network providers.
i. AAH will incorporate the standard terms and conditions provided by DHCS, in addition to AAH's own terms, to develop contracts with ICF-DD Home/SA/PSA Providers. If the AAH contract substantially deviates from these terms and conditions, AAH will submit to DHCS for review and approval.

~~3.~~12. The Alliance shall pay providers, including institutional providers, in accordance with the prompt payment provisions contained in the DHCS contract and APL 23-020 Requirements for Timely Payment of ~~,~~Claims, including the ability to accept and pay electronic claims. AAH will allow an invoicing process with minimum necessary data elements for ICF-DD Home/SA/PSAs unable to submit electronic claims. AAH will provide required training to Providers on payment processes.

13. The Alliance shall pay non-contracted provider claims in accordance with Health &Safety Code Sections 1371– 1371.39 and/or other applicable laws and regulations. The Alliance is subject to any remedies, including interest payments, provided for in DHCS regulations if the Alliance fails to meet the standards specified in these sections. If the submitting provider requests electronic processing, the Alliance shall accept the submission of electronic claims and pay claims electronically.

14. This reimbursement requirement applies only to SNF services as defined in Title 22 CCR Sections 51123(a), 51511(b), 51535, and 51535.1, as applicable, starting on the first day of a Member's stay, which include:
    a. SNF services as set forth in Title 22 CCR section 51123(a) to include:
        i. Room and board.
        ii. Nursing and related care services.
        iii. Commonly used items of equipment, supplies, and services as set forth in Title 22 CCR section 51511(b).
    b. Leave-of-absence days as set forth in Title 22 CCR section 51535.

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c. Bed holds as set forth in Title 22 CCR section 51535.1.

15. Medi-Cal FFS per-diem rates for SNF services are all-inclusive rates that account for both skilled and custodial levels of care and are not tiered according to the level of care. Ancillary services are excluded from the services bundled under the Medi-Cal FFS per-diem rates, but when medically necessary, are provided to members.

16. The reimbursement requirement does not apply to any other services provided to a Member receiving SNF services such as, but not limited to, services outlined in Title 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d), SNF services provided by an Out-of-Network Provider of SNF services, or services that are not provided by a Network Provider of SNF services. Such non-qualifying services are not subject to the terms of State directed payments and are payable by AAH in accordance with terms negotiated between AAH and the Provider.

~~4.~~17. The reimbursement requirement applies only to payments made directly for SNF services rendered, and does not apply to other types of payments, including, but not limited to, Provider incentive and pay-for-performance payments.

~~5.~~18. The Alliance shall reimburse providers at rates that are not less than Medi-Cal Fee-for-Service (FFS) rates, as published and revised by DHCS, including retroactive payment.

19. Pursuant to W&I Code Section 14186.1(c)(4), ~~MCPs shall~~AAH includes as a covered benefit any leave of absence or bed-hold of any additional rate increment based on DHCS retroactive rate adjustments, for equivalent services for the date(s) of service that a NF provides in accordance with the requirements of Title 22, California Code of Regulations (CCR), Section 72520 or California's Medicaid State Plan. 1 Medi-Cal requirements for bed-hold and leave of absence are detailed in Title 22, CCR, Sections 51535 and 51535.1.

20. ICF/DD Home/SA/ICF Payment Rate

a. In accordance with W&I section 14184.201(c)(2), for contract periods from January 1, 2024, to December 31, 2025, inclusive, AAH will reimburse a Network Provider furnishing ICF/DD Home/SA/PSA services to a Member, and each Network Provider of ICF/DD Home/SA/PSA services must accept, the payment amount the Network Provider would be paid for those services in the FFS delivery system, as defined by DHCS in the Medi-Cal State Plan and as authorized by W&I sections 14105.075(b) and 14184.102(d).

b. This reimbursement requirement is subject to the Centers for Medicare and Medicaid Services' (CMS) approval as a state-directed payment arrangement in accordance with 42 Code of Federal Regulations (CFR) section 438.6(c) and is subject to future budgetary authorization and appropriation by the California Legislature.

c. AAH will reimburse Network Providers of ICF/DD Home/SA/PSA services for those services at exactly the Medi-Cal FFS per-diem rates applicable to that particular type of ICF/DD Home/SA/PSA services Provider for dates of service from January 1, 2024, through December 31, 2025, in accordance with W&I section 14184.201(c)(2), APL 23-023 and the terms of the CMS-approved directed payment preprint.

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d. These state-directed payment requirements only apply to inclusive per diem ICF/DD Home/SA/PSA services as defined in 22 CCR sections 51510.1, 51510.2, and 51510.3, as applicable, and listed in Attachment A, starting on the first day of a Member's living arrangement. They do not apply to any other services provided to a Member living in an ICF/DD Home/SA/PSA, including, but not limited to, services outlined in 22 CCR section 51165(b), services provided by any Out-of-Network Provider, and any services that are not provided by a Network Provider of ICF/DD Home/SA/PSA services at the per diem rate.

i. For SA/PSA facilities, Medi-Cal FFS per diem rates for adult subacute care services are all-inclusive rates differentiated between ventilator and non-ventilator accommodation codes. Medi-Cal FFS per diem rates for pediatric subacute care services are all-inclusive rates differentiated between ventilator, non-ventilator, ventilator weaning, and rehab therapy accommodation codes. This reimbursement requirement applies only to payments made directly for adult or pediatric subacute care services rendered, and does not apply to other types of payments, including but not limited to, Provider incentive and pay-for-performance payments.

~~6.~~e.

~~7.~~21. For Members with Medicare and MediCal coverage and Other Health Coverage (OHC), the Alliance is responsible for ensuring coordination of benefits, cost avoidance and Post payment recovery in accordance with APL ~~21-002~~22-027. For Long Term Care (LTC) services, the Alliance shall pay the full Medicare coinsurance and deductibles as defined in APL 13-003 or the most recent version of APL related to Coordination of Benefits

~~8.~~22. The Alliance shall process claims submitted by NF/ICF-DD/SA/PSAs consistent with Medi-Cal guidelines for Share of Cost (SOC), as outlined in the Medi-Cal Long-Term Care Provider Manual. When a Medi-Cal ~~beneficiary~~Member has an LTC aid code and a SOC, a NF/ICF-DD/SA/PSA will submit the SOC amount on the claim which will be used to offset any payment due to the provider. The Alliance shall pay the balance.

~~9.~~23. **Continuity of Care**: For Members residing in LTC ~~after~~ as of January 1, 2023, the Alliance ensures eligible Members will have continued residency in the nursing facilities:

a. For up to 12 months for seniors and persons with disabilities (SPD) ~~beneficiaries~~Members who are currently residing in a SNF.

b. By recognizing any SNF services treatment authorization requests (TAR) made by DHCS for the member enrolled into ~~the MCP~~AAH.

24. 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 23-023 for ICF/DD and the final APL for Subacute carve in. 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.~~.~~

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AAH will allow 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 the following apply:
The ICF-DD Home/SA/PSA is licensed by CDPH;
• 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 state statutory requirements, and
• The ICF-DD Home/SA/PSA meets AAH's applicable professional standards and has no disqualifying quality-of-care issues.

a. 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.

~~b.~~25.

~~10.~~26. The Alliance ~~must~~ 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 ~~beneficiary~~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 ~~beneficiary~~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 MediCal 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 14-021).

If a ~~beneficiary~~Member was residing in an out-of-network skilled nursing facility (SNF,) ICF/DD or Subacute facility when the ~~beneficiary~~Member transitioned into the Alliance, the Alliance shall offer the ~~beneficiary~~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 ~~beneficiary~~Member is discharged from the SNF/ICF-DD/Subacute facility into the community or a lower level of care.

~~11.~~27. The Alliance shall maintain continuity of care by recognizing any treatment authorizations made by DHCS for NF/ICF-DD/Subacute services that were in effect when the ~~beneficiary~~Member enrolled into the Alliance consistent with APL ~~18-008.~~23-022. The Alliance shall honor such treatment authorizations for 12 months or for the duration of the treatment authorization if the remaining authorized duration is less than 12 months, following enrollment of a ~~beneficiary~~Member into the Alliance.

~~12.~~28. A ~~beneficiary~~Member who is a resident of an NF/ICF-DD/Subacute facility prior to enrollment with the Alliance will not be required to change ~~NFs~~ facilities if:

a. the facility is licensed by the California Department of Public Health, (CDPH.)
b. meets acceptable quality standards, and

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c. the facility agrees to Medi-Cal rates in accordance with the Alliance contract with DHCS. This provision is automatic, meaning a ~~beneficiary~~Member does not have to make a request to ~~the MCP~~AAH to invoke this provision.

29. 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 ICF/DD 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.

~~c.~~

~~13.~~30. The Alliance maintains processes to support NF/ICF-DD/SA/PSA in the event of a change in ~~beneficiary~~Member's condition and discharge. A NF/ICF-DD/SA/PSA may modify its care of a ~~beneficiary~~Member or discharge the ~~beneficiary~~Member if the NF/ICF-DD/SA/PSA determines that the following specified circumstances are present:

a. The NF/ICF-DD/SA/PSA is no longer capable of meeting the ~~beneficiary~~Member's health care needs;
b. The ~~beneficiary~~Member's health has improved sufficiently so that he or she no longer needs NF/ICF-DD/SA/PSA services; or
c. The ~~beneficiary~~Member poses a risk to the health or safety of individuals in the NF/ICF-DD/SA/PSA.

31. The Alliance is responsible for ensuring that delegates comply with all applicable state and federal laws and regulations and other contract requirements and DHCS guidance.

32. Facility Transitions:

When transitioning Members to and from Skilled Nursing Facilities, (and in 2024, for 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:

a. 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.)

b. 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,

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(IHSS,) Community Supports, Long Term Services and Supports, (LTSS,) and other Home and Community Based Services, (HCBS);

c. 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;

d. Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

e. Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

f. 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.

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~~14.~~33. The Alliance ~~will~~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.

~~a. Complex Care Management~~

~~b. Enhanced Care Management~~

As part of BPHM, AAH ensures that members are engaged with their assigned Primary Care Providers, including arranging transportation. 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.

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As part of the PHM Program, AAH provides TCS, implemented in a phased approach. As of January 1, 2023, AAH implemented timely prior authorizations for all Members, and knows when all Members are admitted discharged, or transferred from facilities,

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including SNFs, and will include ICF-DD/Subacute facilities in 2024. 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 activities are completed. By January 1, 2024, AAH will ensure all TCS are completed for all Members, including those in SNFs /ICF-DD/Subacute facilities. The Alliance provides Transitional Care Services to include:

a. Timely authorizations for all Members

b. Awareness of when all Members are admitted, discharged, and transferred

c. 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.

34. 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 be 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.

Effective January 1, 2024, 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 AAN 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.

35. The Alliance works with DHCS and network providers to obtain documentation validating Preadmission Screening and Resident Review (PASRR,) completion for Members who may be admitted into a NF/SA/PSA facility for a long-term stay which ensures the facility admission is appropriate, if the member fails the first screen.

~~15.~~36. The Alliance is responsible for identifying and maintaining quality services and outcomes for MediCal NF/ICF-DD/SA/PSA services. The Alliance ~~will~~

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integrates DHCS-specified health care service quality measures and self-identified quality measures. The Alliance ~~will~~ submits the DHCS-specified health care service quality data at a frequency identified by DHCS.

~~16.~~37. The Alliance will work with SNF/ICF-DD/Subacute facilities for care planning and coordination of transitional needs of members receiving SNF/ICF-DD/Subacute facility services into and out of complex case management services:

a. At the request of primary care physician or member
b. When the member has an acute care episode which triggers an inpatient stay
c. Achievement of targeted outcomes
d. Change of healthcare setting
e. Loss or change in benefits.
f. Member non-compliance

~~f.~~

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~~17.~~38. The Alliance Pharmacy will work with SNF/ICF-DD/Subacute facility or custodial facility as follows:

a. Skilled Nursing Facilities (SNF)
   i. Pharmacy Department ~~will~~ coordinates medication requests submitted through medical claims for appropriate coverage.
   ii. Pharmacy drugs and enteral nutrition are covered through the medical benefit as a part of a bundle.
   iii. Medical benefit prescription medications or pharmacy services that are not covered as part of the bundled rate must be submitted to the Alliance for payment.
b. Custodial Care Facilities (LTC)
   i. Pharmacy Department ~~will~~ coordinates medication requests submitted through medical claims for appropriate coverage.
   ii. Pharmacy drugs and enteral nutrition are covered through Medi-Cal Rx.

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c. ICF-DD/SA/PSA Facilities

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i. Financial responsibility for prescription drugs is determined by the claim type on which they are billed. If certain drugs are dispensed by a pharmacy and billed on a pharmacy claim, they are carved out and paid by Medi-Cal Rx. The Medi-Cal FFS ICF/DD Home per diem rate does not include legend drugs (prescription drugs). If the drugs are provided by the ICF/DD Home and billed on a medical or institutional claim, AAH is responsible. AAH may cover drugs not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered. AAH complies with PHM requirements, which include the coordination of medically necessary drugs or medications on behalf of the Member.

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ii.

~~18.~~39. The Alliance is responsible for ensuring access to

a. Routine and unusual specialty referral and access
b. Ancillary services in the LTC setting. The Alliance ~~will~~ approves Authorization Requests for covered therapy services when necessary for a ~~Nursing~~ 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).~~—~~.

~~19.~~40. The Alliance ensures timely provision of access standards with appropriate clinical timeframes for specialty appointments as indicated in the AAH LTC Program Description.

~~20.~~41. Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it ~~must be~~is documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.

~~21.~~42. The Alliance is responsible for arranging for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards are not available, or there is a shortage of appropriate providers. To ensure access to services, the Alliance ~~will~~ refers Members to, or assist Members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner appropriate for the Member's needs.

~~22.~~43. The Alliance adheres to the requirements and maintains mechanisms to ensure contracted providers and facilities comply with the requirements of Title III of the Americans with Disabilities Act of 1990 as described in the AAH LTC Program Description.

PROCEDURE

Authorization processes for medical services including nursing facility provider.

1. The facility shall submit the following to the Alliance LTC Department:
   a. Completed LTC Authorization Request Form (ARF) (Sections I through V), including a physician signature, with the request for LTC retroactive authorization, within one hundred twenty (120) calendar days of the State of California's eligibility determination for Medi-Cal, regardless of when the

facility identifies eligibility. Facilities are advised not to wait for a DHCS Notice of Action to identify retroactive eligibility.

b. Copy of denial letter or another document is required, as applicable:
  - **i.** Notice of Action (NOA); or
  - **ii.** Integrated Denial Notice (IDN); or
  - **iii.** Notice of Medicare Non-Coverage (NOMNC); or
  - **iv.** Other Health Care (OHC) Explanation of Benefit.

c. Electronic Preadmission Screening Resident Review (PASRR) Level I Screening Document (initial requests only) if the Member fails the first ~~(~~screen. (ICF/DD, ICF/DD-H, and ICF/DD-N facilities are exempt). AAH works with DHCS and network providers, including discharging facilities or admitting nursing facilities, to obtain documentation validating PASRR process completions

d. For NFs:

  ~~**d.**~~**i.** Most recent Minimum Data Set (MDS), either full assessment for admission or the latest quarterly assessment for continued stay.

  ~~**e.**~~ Nurses' notes, Social Services Agency evaluations, or physician orders if the MDS Version 3.0 (asterisked sections) does not reflect the need for skilled care placement.

Continuity of Care

1. For Members residing in LTC after January 1, 2023, the Alliance ensures eligible Members will have continued residency in the nursing facilities:

- For up to 12 months for seniors and persons with disabilities (SPD) ~~beneficiaries~~Members who are currently residing in a SNF.
- By recognizing any SNF/ICF-DD/Subacute services treatment authorization requests (TAR) made by DHCS for the member enrolled into ~~the MCP~~AAH for NF~~.~~.
- Effective January 1, 2024, AAH is responsible for TARs approved by DHCS, hereafter referred to as "authorization requests" for ICF/DD Home/SA/PSA services provided under the ICF/DD Home/SA/PSA per diem rate for the duration of the treatment authorization for existing authorization requests and for of up to two years for any new requests.
- AAH is responsible for all other approved authorization requests for services in an ICF/DD Home, exclusive of the ICF/DD Home per diem rate for a period of 90 days after enrollment in AAH, or until AAH is able to reassess the Member and authorize and connect the Member to medically necessary services.
  - **For SA/PSA:**
  - AAH is responsible for covering treatment authorization requests (TARs) that are approved by DHCS and provided under the Subacute Care Facility per diem rate for a period of six months after enrollment in AAH, or for the duration of the TAR approval, whichever is shorter. AAH will honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, authorized representative, or Provider in accordance with the requirements in APL 23-022, or any superseding APL.
  - Subsequent reauthorizations are approved for up to six months. Reauthorizations are approved for one year as long as the pediatric subacute

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care criteria are met. Approval for pediatric subacute care services cease once the Member turns 21 years of age. Discharge planning to an adult Subacute Care Facility will be completed at least two months prior to the Member turning 21 years of age.

- Effective January 1, 2024, AAH is responsible for covering all other services approved by DHCS' TARs (except for supplemental rehabilitation therapy services and ventilator weaning services for Members in pediatric Subacute Care Facilities, as discussed below) provided in a Subacute Care Facility exclusive of the Subacute Care Facility per diem rate for a period of 90 days after enrollment in AAH. AAH will honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, authorized representative, or Provider in accordance with the requirements in APL 23-022, or any superseding APL.
- After 90 days, the TAR approval remains in effect for the duration of the approved TAR or until completion of a new assessment by AAH, whichever is shorter. A new assessment is considered complete by AAH if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider and the Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition TAR approval.
- AAH covers supplemental rehabilitation therapy services and ventilator weaning services for DHCS-approved TARs in a Subacute Care Facility for a period of 90 days after enrollment in AAH. After 90 days, the TAR approval remains in effect for the duration of its approval period, or until completion of a new assessment by AAH, whichever is shorter

2. ~~2.~~ A Member entering managed care residing in a SNF who newly enrolls in AAH on or after July 1, 2023~~after June 30, 2023~~, does not receive automatic continuity of care and must instead request continuity of care, following the process established by APL ~~18-008~~23-022 Continuity of Care or any superseding APL.
3. A Member residing in a Subacute Care Facility who newly enrolls in AAH on or after July 1, 2024, does not receive automatic continuity of care and must instead request continuity of care, following the process established by APL 23-022, or any superseding APL. Pursuant to APL 22-032, or any superseding APL, AAH will notify the Member or their authorized representative of the Member's right to request continuity of care and furnish a copy of the notification to the ICF/DD Home/SA/PSA in which the Member resides.
4. ICF-DD Home/SA/PSAs are a long-term home living setting, and AAH will not change these living arrangements unnecessarily. The 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 the continuity of care period, AAH will automatically provide 12 months of continuity of care for the ICF-DD Home/SA/PSA placement of any Member residing in an ICF-DD Home/SA/PSA who is mandatorily enrolled into AAH after January 1, 2024. Automatic continuity of care means that Members currently residing in an ICF-DD Home/SA/PSA do not have to request continuity of care to continue to reside in the ICF-DD

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Home/SA/PSA. AAH will automatically initiate the continuity of care process prior to the Member's transition to the AAH. AAH will determine if Members are eligible for automatic continuity of care before the transition by identifying the Member's ICF-DD Home/SA/PSA residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the Member or Provider, if not otherwise available from DHCS.

5. While Members must meet medical necessity criteria for 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.

   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.

   Following their initial 12-month continuity of care period, Members or their authorized representatives may request an additional 12 months of continuity of care.

   Under continuity of care, Members may continue seeing their Out-of-Network Medi-Cal Provider if the Member, authorized representative, or Provider contacts the AAH to make the request. AAH will provide continuity of care for all medically necessary ICF-DD Home/SA/PSA services for Members residing in an ICF-DD Home/SA/PSA at the time of enrollment with AAH, including professional services, ancillary services, and transportation services not already provided in the ICF-DD Home/SA/PSA per diem rate. AAH will also provide the appropriate level of care coordination, in adherence to contractual requirements.
6. AAH will provide continuity of care for Members that are transferred from a NF/ICF-DD/SA/PSA facility to a general acute care hospital, and then require a return to NF/ICF-DD/SA/PSA facility level of care due to Medical Necessity.
7. If a Member is unable to access continuity of care as requested, AAH will provide the Member or their authorized representative with a written notice of action of an adverse benefit determination in accordance with APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates, or any superseding APL. A copy of the notification must also be provided to the Subacute Care Facility in which the Member resides.

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8. AAH will also comply with the discharge requirements in HSC section 1373.96 and WIC section 14186.3(c)(4).

53. . Additional procedures implemented as are outlined in UM 036-Continuity of Care for Terminated and Non-Participating providers, and UM 058059- Continuity of Care for new enrollees transitioned to Managed Care after receiving medical exemptionMedi-Cal Beneficiaries Transitioning into Managed Medi-Cal.

Regional Center/ICF-DD Role in Planning

1. Regional Center role
   1.1. 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.
      1.1.1. 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.
      1.1.2. 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.
2. ICF-DD role
   An Individual Service Plan (ISP) is developed by the ICF/DD Home's interdisciplinary professional staff/team, and includes participation of the 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.

Change in a ~~Beneficiary~~Member's Condition

1. When a change of condition or change from baseline is observed and reported~~.~~. The Facility shall submit the following to the Alliance:
   a. Complete the LTC Authorization Request Form (ARF) including the physician signature;
   b. Attach current Nurse's notes highlighting the change of condition:
      i. abnormal or change in vital signs.
      ii. skin breakdown, open areas, rashes, and indications of bleeding
      iii. weight loss, gain, change in appetite
      iv. diarrhea, nausea, and vomiting

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v. respiratory distress
vi. signs and symptoms of acute infections
vii. falls

Delegation Oversight

I. Delegation Oversight Meetings

a. The Alliance ~~will~~ assesses and monitors the effectiveness of communication and coordination of processes between the Alliance and the contracted delegate. Quarterly meetings may be conducted with the delegate to discuss items such as:

i. Compliance with the applicable standards;
ii. Clinical and service quality improvement projects/activities;
iii. Performance and plans for improvement related to annual goals and objectives;
iv. Member complaint and appeal issues;
v. New regulatory and/or legislative changes;
vi. vi. Findings from annual program and file audit

II. Reporting Requirements

a. Contractual Reporting

The delegate ~~will~~ submits all contractual reports to the Compliance Department, in a format acceptable to the Alliance in accordance with their delegation agreement. The Compliance Department ~~will~~ reviews the reports and forward them to the applicable operational department for feedback, recommendations, and any CAP if applicable.

i. The contracted delegate is required to respond to areas of deficiency within 30 days. The oversight review ~~will~~ includes mechanisms for corrective action and follow-up requests. Any area of non-compliance will require a Corrective Action Plan (CAP) or response within 30 days of receipt of the results. Failure to provide the requested information or to implement a CAP may result in further action including termination as specified in the Delegation Agreement. All reporting corrective action plans will be reported to the Delegation Oversight Committee.

b. Regulatory Reporting

The delegate will submit all regulatory reports to the Compliance Department that are required by applicable state and federal regulations. The Compliance Department will review and forward to the applicable operational department for feedback, recommendations, and any CAP if applicable. If issues are found, the Compliance Department will require a response as well as an internal CAP from the delegate prior to submitting it to the applicable state or federal regulatory body. All reporting CAPs will be reported to the Delegation Oversight Committee.

III. Ongoing Monitoring of Performance

The Alliance ~~will~~ monitors its delegates through various methods such as contractual reporting, regulatory reporting, annual audits, and dashboards to evaluate the delegate's performance and for determining the resumption of delegated functions. If the delegate fails to perform appropriately and/or does not adhere to the contractual requirements, the Alliance will issue a CAP to the delegate. Failure to complete the CAP or resolving the compliance issues could potentially lead to Alliance de-delegating the function, financial sanctions~~-~~, escalation to Senior Plan leadership or terminating the delegate's contract agreement.

Quality Measures

1) On the date of receipt of the LTC PQI referral from AAH LTC Manager, RN case owner ~~will~~ sends medical request letter to LTC facility after confirming correct contact person and fax or email.
2) RN case owner ~~will~~ notifies ~~they~~ LTC Manager of receipt of PQI and expedited status for medical record request.
3) If ~~no~~there is no response to medical request letter within 10 business days, RN case owner will follow up with LTC facility to verify medical record request status.
4) If no response within 5 business days of RN follow-up call, case will be escalated to QI Supervisor for escalation call to facility.
5) If no response within 5 business days of QI Supervisor escalation call, case will be escalated to QI Senior Director for follow-up call.
6) Once medical records are received, the RN case owner will begin investigation within 2 business days of receipt and present them to QI Senior Medical Director at next QOC review meeting for final leveling.
7) Once final leveling is determined by the QI Senior Medical Director, the findings will be shared with the LTC Manager as a case file PDF via email by RN case owner.

Quality Monitoring

1) 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 be limited to, survey deficiency results, site visit findings, and complaint findings.
2) The AAH QAPI program incorporates:
   A. Contracted NF/SA/PSA's QAPI programs, including the 5 key CMS elements:
      i. Design and Scope
      ii. Governance and Leadership
      iii. Feedback, Data Systems and Monitoring
      iv. Performance Improvement Projects
      v. Systematic Analysis and Systematic Action
   B. Claims data for NF/SA/PSA residents, including but not limited to emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions as well as DHCS supplied WQIP data via a template provided by DHCS on a quarterly basis.

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C. Mechanisms 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. DHCS and CDPH efforts to prevent detect, and remediate identified critical incidents

3) The Alliance will report on LTC measures per the Managed Care Accountability Set (MCAS) of performance measures and will submit QAPI program reports on an annual basis to DHCS. AAH will calculate the rates for each MCAS LTC measure for each NF/SA/PSA Facility in the Network for each reporting unit. AAH will adhere to quality and enforcement standards in APL 19-017 and APL 22-015, respectively, or any superseding APLs

4) AAH will monitor quality and appropriateness of care provided to Members who reside at contracted ICF/DD Homes through the establishment of an ICF/DD Home's quality assurance program. AAH will establish a mechanism to receive ICF/DD Homes' oversight and compliance findings and data from the California Department of Public Health (CDPH), as well as service delivery findings from the Regional Centers, through the AAH and RCEB's executed Memoranda of Understanding so that information can be included in the quality assurance program.
Upon DHCS request, AAH will submit quality assurance reports with outcome and trending data.

AAH will implement quality monitoring and appropriateness of care provided to Members in Subacute facilities through a quality assurance program, as required by applicable final Subacute APL for Members coming into AAH in 2024. AAH will work with the Regional Center of the East Bay to receive facility oversight and compliance data as part of quality assurance.

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DEFINITIONS / ACRONYMS

1. **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."

~~1.~~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).

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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)** provides care for members with a developmental disability with complex medical problems requiring skilled care or observation on an ongoing intermittent basis and 24 hour supervision. Criteria for Subacute Services is in section 7.3 and 7.4 of the Medical Provider Manual.

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AFFECTED DEPARTMENTS/PARTIES

1. Long Term Care
2. ~~Customer~~ Member Services
3. Utilization Management
4. Claims Department
5. Provider ~~Network Operations~~Relations
6. Quality Management
7. Grievance and Appeals
8. ~~7.~~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-001CCM Identification Screening, Enrollment, and Identification
CM-010 ECM Enrollment
CM-011 Enhanced Care Management
CM-027- Community Supports-Oversight, Monitoring and Controls

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

02/21/2023

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
Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and Your Rights
DHCS APL ~~14-004~~23-022: Continuity of Care
DHCS APL ~~16-003: Long Term Care~~23-004 Skilled Nursing Facilities-Long Term Care Benefit Standardization and Transition of Members to Managed 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) 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
DHCS 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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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.

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

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	Manager, Long Term Care
Line(s) of Business	Medi-Cal
Effective Date	01/01/2023
Approval/Revision Date	TBD

POLICY STATEMENT

1. This policy governs the policy and practices for providing Long Term Care (LTC) services in the following settings:
    a. LTC Nursing Facilities (NF)
    b. Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD)
    c. Subacute (SA) care facilities
    d. Pediatric Subacute (PSA) care facilities.
2. The Alliance shall authorize utilization of LTC facilities and services for their Members when medically necessary. AAH will cover all Medically Necessary services for Members residing in or obtaining care in a NF/ICF-DD/SA/PSA Facility, including facility services, professional services, and ancillary services such as therapy (physical, occupational, speech therapy). AAH will also provide the appropriate level of care coordination, including for carved-out Medi-Cal services, as outlined in APLs and in adherence to contractual requirements and the DHCS PHM Policy Guide
3. AAH Members will 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. Effective January 1, 2024, institutional LTC Members receiving institutional LTC services in a Subacute Care Facility (SA or PSA,) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) will be enrolled in AAH. The Alliance shall authorize utilization of ICF-DD/SA/PSA services for their Members when medically necessary.
5. **Intermediate Care Services** 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 service system. Members who:
   - Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care.
   - Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.
   - Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.
6. 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:
   - 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.
   - 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.
   - 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.

7. 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.

8. **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.
9. **Pediatric subacute care** is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

10. 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. AAH will adhere to the timeliness of authorization requirements applicable to each category of LTSS facilities.
11. Network: The Alliance endeavors to contract with all NF/ICF-DD/SA/PSA providers in its service area and shall comply with all applicable CMS and DHCS requirements established under Welfare and Institutions Code (W&I) Section 14186.3(c)(5), in order to ensure timely access. For Pediatric Subacute Facilities, (PSAs,) AAH will attempt to contract with all PSA facilities statewide. For SA/PSA Facilities, AAH will assure that the facility has a Subacute Care Contract with DHCS' SCU or are actively in the process of applying for a Medi-Cal Subacute Care Contract and are enrolled in Medi-Cal.
    a. Effective January 1, 2024, AAH will have and maintain an adequate network consisting of ICF/DD Homes, ICF/DD-H Homes, and ICF/DD-N Homes and SA/PSA facilities licensed and certified by the California Department of Public Health (CDPH.) The Network will include at minimum one (1) of each ICF/DD Home type within California, prioritizing ICF/DD Homes in Alameda county when available.
    b. AAH will develop sufficient Network capacity to enable timely Member placement in NF/ICF-DD/SA/PSA facilities within 5 business days of a request, as outlined in Welfare and Institutions Code (WIC) section 14197.[1] A Letter of Agreement does not constitute a Network Provider Agreement
    c. AAH will streamline credentialing and recredentialing processes for ICF-DD Home/SA/PSAs using materials submitted by ICF-DD Home/SA/PSAs to CDPH, DDS, and DHCS.
    d. AAH will also make every effort to assess the various provider types currently serving ICF-DD Home/SA/PSA residents receiving Medi-Cal covered services and maintain an adequate network with them. AAH will make every effort to contract with the providers serving Members to ensure care is not disrupted. If all efforts to contract with providers currently working with Members have been exhausted, AAH will offer the Member a choice of a network provider to transition services. AAH will ensure that the network providers are equipped and appropriately trained to work with individuals with intellectual and developmental disabilities.
    e. AAH ensures that network providers have appropriate training on benefits coordination, including the prohibition on balance billing.

[1] State law is searchable at: https://leginfo.legislature.ca.gov/

f. AAH will ensure contracted ICF-DD Home/SA/PSA Providers receive a preapproval or assessment of suitability from CDPH prior to the execution of a Network Provider Agreement for ICF-DD Home/SA/PSA Providers undergoing a change of ownership. AAHs' Network Provider Agreements with ICF-DD Home/SA/PSA Providers will have a clause stating ICF-DD Home/SA/PSA Providers will notify AAH whether it is undergoing a change of ownership so the ICF-DD Home/SA/PSA can obtain preapproval or assessment of suitability from CDPH.
g. Per APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations, or any superseding APL, AAH will comply with requirements relating to CDPH initiated facility de-certifications and licensure suspensions. To ensure Members' health and safety, AAH will work with Regional Center to coordinate care and if necessary, work jointly to transition Members appropriately.
h. AAH is responsible for ensuring that any Subcontractors and network providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs. These requirements are communicated by AAH to all Subcontractors and network providers.
i. AAH will incorporate the standard terms and conditions provided by DHCS, in addition to AAH's own terms, to develop contracts with ICF-DD Home/SA/PSA Providers. If the AAH contract substantially deviates from these terms and conditions, AAH will submit to DHCS for review and approval.

12. The Alliance shall pay providers, including institutional providers, in accordance with the prompt payment provisions contained in the DHCS contract and APL 23-020 Requirements for Timely Payment of Claims, including the ability to accept and pay electronic claims. AAH will allow an invoicing process with minimum necessary data elements for ICF-DD Home/SA/PSAs unable to submit electronic claims. AAH will provide required training to Providers on payment processes.
13. The Alliance shall pay non-contracted provider claims in accordance with Health &Safety Code Sections 1371– 1371.39 and/or other applicable laws and regulations. The Alliance is subject to any remedies, including interest payments, provided for in DHCS regulations if the Alliance fails to meet the standards specified in these sections. If the submitting provider requests electronic processing, the Alliance shall accept the submission of electronic claims and pay claims electronically.
14. This reimbursement requirement applies only to SNF services as defined in Title 22 CCR Sections 51123(a), 51511(b), 51535, and 51535.1, as applicable, starting on the first day of a Member's stay, which include:
    a. SNF services as set forth in Title 22 CCR section 51123(a) to include:
        i. Room and board.
        ii. Nursing and related care services.
        iii. Commonly used items of equipment, supplies, and services as set forth in Title 22 CCR section 51511(b).
    b. Leave-of-absence days as set forth in Title 22 CCR section 51535.
    c. Bed holds as set forth in Title 22 CCR section 51535.1.

15. Medi-Cal FFS per-diem rates for SNF services are all-inclusive rates that account for both skilled and custodial levels of care and are not tiered according to the level of care. Ancillary services are excluded from the services bundled under the Medi-Cal FFS per-diem rates, but when medically necessary, are provided to members.
16. The reimbursement requirement does not apply to any other services provided to a Member receiving SNF services such as, but not limited to, services outlined in Title 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d), SNF services provided by an Out-of-Network Provider of SNF services, or services that are not provided by a Network Provider of SNF services. Such non-qualifying services are not subject to the terms of State directed payments and are payable by AAH in accordance with terms negotiated between AAH and the Provider.
17. The reimbursement requirement applies only to payments made directly for SNF services rendered, and does not apply to other types of payments, including, but not limited to, Provider incentive and pay-for-performance payments.
18. The Alliance shall reimburse providers at rates that are not less than Medi-Cal Fee-for-Service (FFS) rates, as published and revised by DHCS, including retroactive payment.
19. Pursuant to W&I Code Section 14186.1(c)(4), AAH includes as a covered benefit any leave of absence or bed-hold of any additional rate increment based on DHCS retroactive rate adjustments, for equivalent services for the date(s) of service that a NF provides in accordance with the requirements of Title 22, California Code of Regulations (CCR), Section 72520 or California's Medicaid State Plan. 1 Medi-Cal requirements for bed-hold and leave of absence are detailed in Title 22, CCR, Sections 51535 and 51535.1.

20. ICF/DD Home/SA/ICF Payment Rate

    a. In accordance with W&I section 14184.201(c)(2), for contract periods from January 1, 2024, to December 31, 2025, inclusive, AAH will reimburse a Network Provider furnishing ICF/DD Home/SA/PSA services to a Member, and each Network Provider of ICF/DD Home/SA/PSA services must accept, the payment amount the Network Provider would be paid for those services in the FFS delivery system, as defined by DHCS in the Medi-Cal State Plan and as authorized by W&I sections 14105.075(b) and 14184.102(d).
    b. This reimbursement requirement is subject to the Centers for Medicare and Medicaid Services' (CMS) approval as a state-directed payment arrangement in accordance with 42 Code of Federal Regulations (CFR) section 438.6(c) and is subject to future budgetary authorization and appropriation by the California Legislature.
    c. AAH will reimburse Network Providers of ICF/DD Home/SA/PSA services for those services at exactly the Medi-Cal FFS per-diem rates applicable to that particular type of ICF/DD Home/SA/PSA services Provider for dates of service from January 1, 2024, through December 31, 2025, in accordance with W&I section 14184.201(c)(2), APL 23-023 and the terms of the CMS-approved directed payment preprint.

    d. These state-directed payment requirements only apply to inclusive per diem ICF/DD Home/SA/PSA services as defined in 22 CCR sections 51510.1,

51510.2, and 51510.3, as applicable, and listed in Attachment A, starting on the first day of a Member's living arrangement. They do not apply to any other services provided to a Member living in an ICF/DD Home/SA/PSA including, but not limited to, services outlined in 22 CCR section 51165(b), services provided by any Out-of-Network Provider, and any services that are not provided by a Network Provider of ICF/DD Home/SA/PSA services at the per diem rate.

i. For SA/PSA facilities, Medi-Cal FFS per diem rates for adult subacute care services are all-inclusive rates differentiated between ventilator and non-ventilator accommodation codes. Medi-Cal FFS per diem rates for pediatric subacute care services are all-inclusive rates differentiated between ventilator, non-ventilator, ventilator weaning, and rehab therapy accommodation codes. This reimbursement requirement applies only to payments made directly for adult or pediatric subacute care services rendered, and does not apply to other types of payments, including but not limited to, Provider incentive and pay-for-performance payments.

e.

21. For Members with Medicare and Medi-Cal coverage and Other Health Coverage (OHC), the Alliance is responsible for ensuring coordination of benefits, cost avoidance and Post payment recovery in accordance with APL 22-027. For Long Term Care (LTC) services, the Alliance shall pay the full Medicare coinsurance and deductibles as defined in APL 13-003 or the most recent version of APL related to Coordination of Benefits
22. The Alliance shall process claims submitted by NF/ICF-DD/SA/PSAs consistent with Medi-Cal guidelines for Share of Cost (SOC), as outlined in the Medi-Cal Long-Term Care Provider Manual. When a Medi-Cal Member has an LTC aid code and a SOC, a NF/ICF-DD/SA/PSA will submit the SOC amount on the claim which will be used to offset any payment due to the provider. The Alliance shall pay the balance.
23. **Continuity of Care**: For Members residing in LTC as of January 1, 2023, the Alliance ensures eligible Members will have continued residency in the nursing facilities:
    a. For up to 12 months for seniors and persons with disabilities (SPD) Members who are currently residing in a SNF.
    b. By recognizing any SNF services treatment authorization requests (TAR) made by DHCS for the member enrolled into AAH.
24. 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 23-023 for ICF/DD and the final APL for Subacute carve in. 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.
    AAH will allow 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 the following apply:

The ICF-DD Home/SA/PSA is licensed by CDPH.
• 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 state statutory requirements, and
• The ICF-DD Home/SA/PSA meets AAH's applicable professional standards and has no disqualifying quality-of-care issues.

a. 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.

25.

26. 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 14-021).

    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 is discharged from the SNF/ICF-DD/Subacute facility into the community or a lower level of care.
27. The Alliance shall maintain continuity of care by recognizing any treatment authorizations made by DHCS for NF/ICF-DD/Subacute services that were in effect when the Member enrolled into the Alliance consistent with APL 23-022. The Alliance shall honor such treatment authorizations for 12 months or for the duration of the treatment authorization if the remaining authorized duration is less than 12 months, following enrollment of a Member into the Alliance.
28. A Member who is a resident of an NF/ICF-DD/Subacute facility prior to enrollment with the Alliance will not be required to change facilities if:
    a. the facility is licensed by the California Department of Public Health, (CDPH.)
    b. meets acceptable quality standards, and
    c. the facility agrees to Medi-Cal rates in accordance with the Alliance contract with DHCS. This provision is automatic, meaning a Member does not have to make a request to AAH to invoke this provision.
29. 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 ICF/DD 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.

30. 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:
    a. The NF/ICF-DD/SA/PSA is no longer capable of meeting the Member's health care needs.
    b. The Member's health has improved sufficiently so that he or she no longer needs NF/ICF-DD/SA/PSA services; or
    c. The Member poses a risk to the health or safety of individuals in the NF/ICF-DD/SA/PSA.
31. The Alliance is responsible for ensuring that delegates comply with all applicable state and federal laws and regulations and other contract requirements and DHCS guidance.
32. Facility Transitions:

    When transitioning Members to and from Skilled Nursing Facilities, (and in 2024, for 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:

    a. 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.)

    b. 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);

    c. 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.

d. Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge.

e. Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

f. 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.

33. 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.

    As part of BPHM, AAH ensures that members are engaged with their assigned Primary Care Providers, including arranging transportation. 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.

    As part of the PHM Program, AAH provides TCS, implemented in a phased approach. As of January 1, 2023, AAH implemented timely prior authorizations for all Members, and knows when all Members are admitted discharged, or transferred from facilities, including SNFs, and will include ICF-DD/Subacute facilities in 2024. 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 activities are completed. By January 1, 2024, AAH will ensure all TCS are

completed for all Members, including those in SNFs /ICF-DD/Subacute facilities. The Alliance provides Transitional Care Services to include:

a. Timely authorizations for all Members

b. Awareness of when all Members are admitted, discharged, and transferred.

c. 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.

34. 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 be 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.

    Effective January 1, 2024, 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 AAN 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.

35. The Alliance works with DHCS and network providers to obtain documentation validating Preadmission Screening and Resident Review (PASRR,) completion for Members who may be admitted into a NF/SA/PSA facility for a long-term stay which ensures the facility admission is appropriate, if the member fails the first screen.

36. The Alliance is responsible for identifying and maintaining quality services and outcomes for Medi-Cal NF/ICF-DD/SA/PSA services. The Alliance integrates DHCS-specified health care service quality measures and self-identified quality measures. The Alliance submits the DHCS-specified health care service quality data at a frequency identified by DHCS.
37. The Alliance will work with SNF/ICF-DD/Subacute facilities for care planning and coordination of transitional needs of members receiving SNF/ICF-DD/Subacute facility services into and out of complex case management services:
    a. At the request of primary care physician or member
    b. When the member has an acute care episode which triggers an inpatient stay
    c. Achievement of targeted outcomes

d. Change of healthcare setting
e. Loss or change in benefits.
f. Member non-compliance

38. The Alliance Pharmacy will work with SNF/ICF-DD/Subacute facility or custodial facility as follows:
    a. Skilled Nursing Facilities (SNF)
        i. Pharmacy Department coordinates medication requests submitted through medical claims for appropriate coverage.
        ii. Pharmacy drugs and enteral nutrition are covered through the medical benefit as a part of a bundle.
        iii. Medical benefit prescription medications or pharmacy services that are not covered as part of the bundled rate must be submitted to the Alliance for payment.
    b. Custodial Care Facilities (LTC)
        i. Pharmacy Department coordinates medication requests submitted through medical claims for appropriate coverage.
        ii. Pharmacy drugs and enteral nutrition are covered through Medi-Cal Rx.
    c. ICF-DD/SA/PSA Facilities
        i. Financial responsibility for prescription drugs is determined by the claim type on which they are billed. If certain drugs are dispensed by a pharmacy and billed on a pharmacy claim, they are carved out and paid by Medi-Cal Rx. The Medi-Cal FFS ICF/DD Home per diem rate does not include legend drugs (prescription drugs). If the drugs are provided by the ICF/DD Home and billed on a medical or institutional claim, AAH is responsible. AAH may cover drugs not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered. AAH complies with PHM requirements, which include the coordination of medically necessary drugs or medications on behalf of the Member.
        ii.
39. The Alliance is responsible for ensuring 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).

40. The Alliance ensures timely provision of access standards with appropriate clinical timeframes for specialty appointments as indicated in the AAH LTC Program Description.
41. Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it is documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.
42. The Alliance is responsible for arranging for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards are not available, or there is a shortage of appropriate providers. To ensure access to services, the Alliance refers Members to, or assist Members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner appropriate for the Member's needs.
43. The Alliance adheres to the requirements and maintains mechanisms to ensure contracted providers and facilities comply with the requirements of Title III of the Americans with Disabilities Act of 1990 as described in the AAH LTC Program Description.

PROCEDURE

Authorization processes for medical services including nursing facility provider.

1. The facility shall submit the following to the Alliance LTC Department:
    - **a.** Completed LTC Authorization Request Form (ARF) (Sections I through V), including a physician signature, with the request for LTC retroactive authorization, within one hundred twenty (120) calendar days of the State of California's eligibility determination for Medi-Cal, regardless of when the facility identifies eligibility. Facilities are advised not to wait for a DHCS Notice of Action to identify retroactive eligibility.
    - **b.** Copy of denial letter or another document is required, as applicable:
        - **i.** Notice of Action (NOA); or
        - **ii.** Integrated Denial Notice (IDN); or
        - **iii.** Notice of Medicare Non-Coverage (NOMNC); or
        - **iv.** Other Health Care (OHC) Explanation of Benefit.
    - **c.** Electronic Preadmission Screening Resident Review (PASRR) Level I Screening Document (initial requests only) if the Member fails the first screen. (ICF/DD, ICF/DD-H, and ICF/DD-N facilities are exempt). AAH works with DHCS and network providers, including discharging facilities or admitting

nursing facilities, to obtain documentation validating PASRR process completions

d. For NFs:

i. Most recent Minimum Data Set (MDS), either full assessment for admission or the latest quarterly assessment for continued stay. Nurses' notes, Social Services Agency evaluations, or physician orders if the MDS Version 3.0 (asterisked sections) does not reflect the need for skilled care placement.

Continuity of Care

1. For Members residing in LTC after January 1, 2023, the Alliance ensures eligible Members will have continued residency in the nursing facilities:

- For up to 12 months for seniors and persons with disabilities (SPD) Members who are currently residing in a SNF.
- By recognizing any SNF/ICF-DD/Subacute services treatment authorization requests (TAR) made by DHCS for the member enrolled into AAH for NF,
- Effective January 1, 2024, AAH is responsible for TARs approved by DHCS, hereafter referred to as "authorization requests" for ICF/DD Home/SA/PSA services provided under the ICF/DD Home/SA/PSA per diem rate for the duration of the treatment authorization for existing authorization requests and for of up to two years for any new requests.
- AAH is responsible for all other approved authorization requests for services in an ICF/DD Home, exclusive of the ICF/DD Home per diem rate for a period of 90 days after enrollment in AAH, or until AAH is able to reassess the Member and authorize and connect the Member to medically necessary services.
    - **For SA/PSA:**
    - AAH is responsible for covering treatment authorization requests (TARs) that are approved by DHCS and provided under the Subacute Care Facility per diem rate for a period of six months after enrollment in AAH, or for the duration of the TAR approval, whichever is shorter. AAH will honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, authorized representative, or Provider in accordance with the requirements in APL 23-022, or any superseding APL.
    - Subsequent reauthorizations are approved for up to six months. Reauthorizations are approved for one year as long as the pediatric subacute care criteria are met. Approval for pediatric subacute care services cease once the Member turns 21 years of age. Discharge planning to an adult Subacute Care Facility will be completed at least two months prior to the Member turning 21 years of age.
    - Effective January 1, 2024, AAH is responsible for covering all other services approved by DHCS' TARs (except for supplemental rehabilitation therapy services and ventilator weaning services for Members in pediatric Subacute Care Facilities, as discussed below) provided in a Subacute Care Facility exclusive of the Subacute Care Facility per diem rate for a period of 90 days after enrollment in AAH. AAH will honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, authorized

representative, or Provider in accordance with the requirements in APL 23-022, or any superseding APL.

- After 90 days, the TAR approval remains in effect for the duration of the approved TAR or until completion of a new assessment by AAH, whichever is shorter. A new assessment is considered complete by AAH if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider and the Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition TAR approval.
- AAH covers supplemental rehabilitation therapy services and ventilator weaning services for DHCS-approved TARs in a Subacute Care Facility for a period of 90 days after enrollment in AAH. After 90 days, the TAR approval remains in effect for the duration of its approval period, or until completion of a new assessment by AAH, whichever is shorter.

2. A Member entering managed care residing in a SNF who newly enrolls in AAH on or after July 1, 2023, does not receive automatic continuity of care and must instead request continuity of care, following the process established by APL 23-022 Continuity of Care or any superseding APL.
3. A Member residing in a Subacute Care Facility who newly enrolls in AAH on or after July 1, 2024, does not receive automatic continuity of care and must instead request continuity of care, following the process established by APL 23-022, or any superseding APL. Pursuant to APL 22-032, or any superseding APL, AAH will notify the Member or their authorized representative of the Member's right to request continuity of care and furnish a copy of the notification to the ICF/DD Home/SA/PSA in which the Member resides.
4. ICF-DD Home/SA/PSAs are a long-term home living setting, and AAH will not change these living arrangements unnecessarily. The 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 the continuity of care period, AAH will automatically provide 12 months of continuity of care for the ICF-DD Home/SA/PSA placement of any Member residing in an ICF-DD Home/SA/PSA who is mandatorily enrolled into AAH after January 1, 2024. Automatic continuity of care means that Members currently residing in an ICF-DD Home/SA/PSA do not have to request continuity of care to continue to reside in the ICF-DD Home/SA/PSA. AAH will automatically initiate the continuity of care process prior to the Member's transition to the AAH. AAH will determine if Members are eligible for automatic continuity of care before the transition by identifying the Member's ICF-DD Home/SA/PSA residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the Member or Provider, if not otherwise available from DHCS.

5. While Members must meet medical necessity criteria for 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.

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.

Following their initial 12-month continuity of care period, Members or their authorized representatives may request an additional 12 months of continuity of care.

6. Under continuity of care, Members may continue seeing their Out-of-Network Medi-Cal Provider if the Member, authorized representative, or Provider contacts the AAH to make the request. AAH will provide continuity of care for all medically necessary ICF-DD Home/SA/PSA services for Members residing in an ICF-DD Home/SA/PSA at the time of enrollment with AAH, including professional services, ancillary services, and transportation services not already provided in the ICF-DD Home/SA/PSA per diem rate. AAH will also provide the appropriate level of care coordination, in adherence to contractual requirements.AAH will provide continuity of care for Members that are transferred from a NF/ICF-DD/SA/PSA facility to a general acute care hospital, and then require a return to NF/ICF-DD/SA/PSA facility level of care due to Medical Necessity
7. If a Member is unable to access continuity of care as requested, AAH will provide the Member or their authorized representative with a written notice of action of an adverse benefit determination in accordance with APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates, or any superseding APL. A copy of the notification must also be provided to the Subacute Care Facility in which the Member resides.
8. AAH will also comply with the discharge requirements in HSC section 1373.96 and WIC section 14186.3(c)(4).

5. 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.

Regional Center/ICF-DD Role in Planning

1. Regional Center role

1.1. 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.

1.1.1. 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.

1.1.2. 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.

2. ICF-DD role

An Individual Service Plan (ISP) is developed by the ICF/DD Home's interdisciplinary professional staff/team, and includes participation of the 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.

Change in a Member's Condition

1. When a change of condition or change from baseline is observed and reported. The Facility shall submit the following to the Alliance:

a. Complete the LTC Authorization Request Form (ARF) including the physician signature.

b. Attach current Nurse's notes highlighting the change of condition:

i. abnormal or change in vital signs.
ii. skin breakdown, open areas, rashes, and indications of bleeding
iii. weight loss, gain, change in appetite.
iv. diarrhea, nausea, and vomiting
v. respiratory distress
vi. signs and symptoms of acute infections
vii. falls

Delegation Oversight

I. Delegation Oversight Meetings

a. The Alliance assesses and monitors the effectiveness of communication and coordination of processes between the Alliance and the contracted delegate. Quarterly meetings may be conducted with the delegate to discuss items such as:

i. Compliance with the applicable standards.

ii. Clinical and service quality improvement projects/activities.
iii. Performance and plans for improvement related to annual goals and objectives.
iv. Member complaint and appeal issues.
v. New regulatory and/or legislative changes.
vi. vi. Findings from annual program and file audit

II. Reporting Requirements

a. Contractual Reporting
The delegate submits all contractual reports to the Compliance Department, in a format acceptable to the Alliance in accordance with their delegation agreement. The Compliance Department reviews the reports and forwards them to the applicable operational department for feedback, recommendations, and any CAP if applicable.
    i. The contracted delegate is required to respond to areas of deficiency within 30 days. The oversight review includes mechanisms for corrective action and follow-up requests. Any area of non-compliance will require a Corrective Action Plan (CAP) or response within 30 days of receipt of the results. Failure to provide the requested information or to implement a CAP may result in further action including termination as specified in the Delegation Agreement. All reporting corrective action plans will be reported to the Delegation Oversight Committee.

b. Regulatory Reporting
The delegate will submit all regulatory reports to the Compliance Department that are required by applicable state and federal regulations. The Compliance Department will review and forward to the applicable operational department for feedback, recommendations, and any CAP if applicable. If issues are found, the Compliance Department will require a response as well as an internal CAP from the delegate prior to submitting it to the applicable state or federal regulatory body. All reporting CAPs will be reported to the Delegation Oversight Committee.

III. Ongoing Monitoring of Performance

The Alliance monitors its delegates through various methods such as contractual reporting, regulatory reporting, annual audits, and dashboards to evaluate the delegate's performance and for determining the resumption of delegated functions. If the delegate fails to perform appropriately and/or does not adhere to the contractual requirements, the Alliance will issue a CAP to the delegate. Failure to complete the CAP or resolving the compliance issues could potentially lead to Alliance de-delegating the function, financial sanctions, escalation to Senior Plan leadership or terminating the delegate's contract agreement.

Quality Measures

1) On the date of receipt of the LTC PQI referral from AAH LTC Manager, RN case owner sends medical request letter to LTC facility after confirming correct contact person and fax or email.
2) RN case owner notifies the LTC Manager of receipt of PQI and expedited status for medical record request.
3) If there is no response to a medical request letter within 10 business days, RN case owner will follow up with LTC facility to verify medical record request status.
4) If no response within 5 business days of RN follow-up call, case will be escalated to QI Supervisor for escalation call to facility.
5) If no response within 5 business days of QI Supervisor escalation call, case will be escalated to QI Senior Director for follow-up call.
6) Once medical records are received, the RN case owner will begin investigation within 2 business days of receipt and present them to QI Senior Medical Director at next QOC review meeting for final leveling.
7) Once final leveling is determined by the QI Senior Medical Director, the findings will be shared with the LTC Manager as a case file PDF via email by RN case owner.

Quality Monitoring

1) 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 be limited to, survey deficiency results, site visit findings, and complaint findings.
2) The AAH QAPI program incorporates:
    A. Contracted NF/SA/PSA's QAPI programs, including the 5 key CMS elements:
        i. Design and Scope
        ii. Governance and Leadership
        iii. Feedback, Data Systems and Monitoring
        iv. Performance Improvement Projects
        v. Systematic Analysis and Systematic Action
    B. Claims data for NF/SA/PSA residents, including but not limited to emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions as well as DHCS supplied WQIP data via a template provided by DHCS on a quarterly basis.
    C. Mechanisms 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. DHCS and CDPH efforts to prevent detect, and remediate identified critical incidents

3) The Alliance will report on LTC measures per the Managed Care Accountability Set (MCAS) of performance measures and will submit QAPI program reports on an annual basis to DHCS. AAH will calculate the rates for each MCAS LTC measure for each NF/SA/PSA Facility in the Network for each reporting unit. AAH will adhere to quality

and enforcement standards in APL 19-017 and APL 22-015, respectively, or any superseding APLs.

4) AAH will monitor quality and appropriateness of care provided to Members who reside at contracted ICF/DD Homes through the establishment of an ICF/DD Home's quality assurance program. AAH will establish a mechanism to receive ICF/DD Homes' oversight and compliance findings and data from the California Department of Public Health (CDPH), as well as service delivery findings from the Regional Centers, through the AAH and RCEB's executed Memoranda of Understanding so that information can be included in the quality assurance program.
Upon DHCS request, AAH will submit quality assurance reports with outcome and trending data.
AAH will implement quality monitoring and appropriateness of care provided to Members in Subacute facilities through a quality assurance program, as required by applicable final Subacute APL for Members coming into AAH in 2024. AAH will work with the Regional Center of the East Bay to receive facility oversight and compliance data as part of quality assurance.

DEFINITIONS / ACRONYMS

1. **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."
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)** provides care for members with a developmental disability with complex medical problems requiring skilled care or observation on an ongoing intermittent basis and 24-hour supervision. Criteria for Subacute Services is in section 7.3 and 7.4 of the Medical Provider Manual.

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-001CCM Identification Screening, Enrollment, and Identification
CM-010 ECM Enrollment
CM-011 Enhanced Care Management
CM-027- Community Supports-Oversight, Monitoring and Controls

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

02/21/2023

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
Department of Health Care Services (DHCS) All Plan Letter (APL) 17-006: Grievance and Appeal Requirements and Revised Notice Templates and Your Rights
DHCS APL 23-022: Continuity of Care
DHCS APL 23-004 Skilled Nursing Facilities-Long Term Care Benefit Standardization and Transition of Members to Managed 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) 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
DHCS APL 23-023 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 Healthcare Quality Committee annually.

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POLICY AND PROCEDURE

Policy Number	LTC -002
Policy Name	Authorization Process and Criteria for Admission, Continued Stay, and Discharge from a Long Term Care Facility
Department Name	Long Term Care
Department Officer	CMO
Policy Owner	Director of LTSS
Line(s) of Business	Medi-Cal
Effective Date	01/01/2023
Approval/Revision Date	TBD

POLICY STATEMENT

This policy outlines the requirements for reviewing and processing Long Term Care (LTC) Authorizations for a Member's admission to, continued stay in, or discharge from a Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B), Intermediate Care Facility-Developmental Disability (ICF/DD), Subacute Facilities (SA) and Pediatric Subacute Facilities (PSA).

POLICY

1. The Alliance's LTC Department shall process all requests for admission to, continued stay in, or discharge from a Nursing Facility (NF) Level A (NF-A) and/or Level B (NF-B) /ICF-DD/SA/PSA pursuant to the Department of Health Care Services (DHCS) standard clinical criteria in the Medi-Cal Manual of Criteria, Chapter 7, Criteria for Long Term Care Services.
2. **Skilled Nursing Facility Level of Care** means that level of care provided by a skilled nursing facility meeting the standards of participation as a Medi-Cal program set forth in section CCR 51215 and CCR 51335(j).
    a. The skilled nursing facility level of care is the level of care needed by Medi-Cal beneficiaries who do not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care, but who require the continuous availability of skilled nursing care provided by licensed registered or vocational nurses, or the equivalent thereof.
    b. Skilled nursing care provided in participating skilled nursing facilities is the composite of necessary observation, assessment, judgment, supervision,

documentation, and teaching of the patient and includes specific tasks and procedures.

c. Skilled nursing procedures provided as a part of skilled nursing care are furnished under the direction of a registered nurse in response to the attending physician's orders, and are either performed or supervised by a licensed registered nurse, a licensed vocational nurse or in the case of institutions for persons with developmental disabilities or distinct parts of institutions which are certified as skilled nursing facilities and providing care for persons with developmental disabilities, by a licensed psychiatric technician. A need for one or more skilled nursing procedures does not necessarily indicate a medical need for skilled nursing facility services. Rather, the need must be for a level of service which includes the continuous availability of procedures such as, but not necessarily limited to, the following: administration of intravenous, intramuscular, or subcutaneous injections, and intravenous or subcutaneous infusions; gastric tube or gastrostomy feedings; nasopharygeal aspiration; insertion or replacement of catheters; application of dressings involving prescribed medications and aseptic techniques; treatment of extensive decubiti and other widespread skin disorders; heat treatments which require observation by licensed personnel to evaluate the patient's progress; administration of medical gases under prescribed therapeutic regimen; and restorative nursing procedures which require the presence of a licensed nurse.

d. Other health care services, such as physical, occupational or speech therapy, require specialized training for proper performance. The need for such therapies does not necessarily indicate a need for nursing facility services.

3. **Intermediate Care Facilities (ICF-DD):** Effective January 1, 2024, AAH will provide all medically necessary covered services for Members residing in or obtaining care in an ICF/DD Home/SA/PSA, including home services, professional services, ancillary services, transportation services and the appropriate level of care coordination, as outlined in APL 23-023, the contract with DHCS, and the Population Health Policy Guide.

   AAH authorizes and covers medically necessary ICF/DD Home services, consistent with definitions in the Medi-Cal Provider Manual. AAH ensures Members in need of ICF/DD Home services, as determined through the IPP and Regional Center authorization, are authorized using the Certification for Special Treatment Program Services form HS 231. Under continuity of care requirements, AAH must receive a copy of the Certification for Special Treatment Program Services form HS 231 as a prerequisite to providing coverage of ICF/DD Home services. 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.

4. **Subacute Facilities (SA):** Effective January 1, 2024, AAH will provide all medically necessary covered services for Members residing in or obtaining care in Subacute

Facilities. Subacute Level of Care means a level of care needed by a member who does not require hospital acute care, but who requires more intensive licensed skilled care than is provided to most patients in a skilled nursing facility

a. To be eligible for subacute level of care a patient's condition shall meet all the criteria as provided for in the Subacute Level of Care Criteria contained in the Manual of Criteria for Medi-Cal Authorization referenced in Title 22, California Code of Regulations (CCR), Section Title 22, California Code of Regulations (CCR), Section 51003(e)as determined by the patient's attending physician

5. **Pediatric Subacute Facilities (PSA):** Effective January 1, 2024, AAH will provide all medically necessary covered services for Members residing in or obtaining care in Pediatric Subacute Care Facilities. Pediatric Subacute 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.
    a. Medical necessity for pediatric subacute services is substantiated by any one of the following items in (1) through (4) below:
        (1) A tracheostomy with dependence on mechanical ventilation for a minimum of six hours each day;
        (2) Dependence on tracheostomy care requiring suctioning at least every six hours, and room air mist or oxygen as needed, and dependence on one of the four treatment procedures listed in (B) through (E) below:
            (A) Dependence on intermittent suctioning at least every eight hours, and room air mist or oxygen as needed;
            (B) Dependence on continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent, via a peripheral or central line, without continuous infusion;
            (C) Dependence on peritoneal dialysis treatments requiring at least four exchanges every 24 hours;
            (D) Dependence on tube feeding, naso-gastric or gastrostomy tube;
            (E) Dependence on other medical technologies is required continuously, which in the opinion of the attending physician, require the services of a professional nurse.
        (3) Dependence on total parenteral nutrition or other intravenous nutritional support, and dependence on one of the five treatment procedures listed in (b)(2)(A) through (E) above;
        (4) Dependence on skilled nursing care in the administration of any three of the five treatment procedures listed in (a)(2)(A) through (E) above.

    b. Medical necessity for pediatric skilled nursing care will also be substantiated by all of the following:
        i. The intensity of medical/skilled nursing care required by the patient shall be such that the continuous availability of a registered nurse in the

pediatric subacute unit is medically necessary to meet the patient's healthcare needs, and not be any less than the nursing staff ratios specified in CCR Section 51215.8(g) and (i);

ii. The patient's medical condition has stabilized such that the immediate availability of the services of an acute care hospital, including daily physician visits, are not medically necessary:

iii. The intensity of medical/skilled nursing care required by the patient is such that, in the absence of a facility providing pediatric subacute care services, the only other medically necessary inpatient care appropriate to meet the patient's health care needs under the Medi-Cal program is in an acute care licensed hospital bed

6. For a non-contracted facility requesting authorization for services, the Alliance shall verify that the facility:

    a. Is licensed by the California Department of Public Health (CDPH);
    b. Meets acceptable quality standards; and
    c. Agrees to the Alliance rates, in accordance with the established Alliance Contract
        i. A non-contracted facility shall provide the required documentation to the Alliance for Credentialing purposes.

7. AAH coordinates benefits with Other Healthcare Coverage (OHC) programs or entitlements in accordance with APL 22-027, Cost Avoidance and Post-Payment Recovery for Other Health Coverage, or any superseding APL. Such coordination of benefits includes recognizing OHC as primary and the Medi-Cal program as the payer of last resort by exercising cost avoidance and conducting post-payment recovery. Members may still utilize their OHC after enrollment in AAH. OHC providers do not have to be in the AAH Network to continue providing services or billing AAH for copays. For Members who are dually Medicare and Medi-Cal covered, or who have OHC, AAH coordinates care and addresses coverage needs, regardless of payer source. Members may receive other benefits from Medicare in addition to the ICF/DD Home benefits that fall to AAH to coordinate.

8. LTC facilities will submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) or the Intermediate Care Facility (ICF) Authorization Request Form
    a. In addition, NF-A or NF-B facilities will also submit the
        i. Minimum Data Set (MDS),
        ii. Preadmission Screening and Resident Review, (PASRR) if the member failed the first screen and
    ~~b.~~ Provider Utilization Committee Determination (Medicare or other insurance denial) if appropriate~~within twenty-one (21) calendar days from the start date of the Alliance LTC coverage.~~

9. AAH ensures that timely access to the NF/ICF/DD Home/SA/PSA benefit is available within five to no more than 14 calendar days of receiving the authorization request from the NF/ICF/DD Home/SA/PSA, as outlined in Welfare and Institutions Code (W&I)

section 14197. AAH expedites prior authorization requests for Members who are transitioning from an acute care hospital to a NF/ICF-DD/SA/PSA facility. AAH makes all authorization decisions in a timeframe appropriate for the nature of the Member's condition, and all authorization decisions are made within 72 hours after AAH receives relevant information needed to make an authorization decision

a. ICF/DD Homes will submit the Certification for Special Treatment Program Services form HS 231 to AAH with any initial or reauthorization requests. AAH will accept the Certification for Special Treatment Program Service*s* form HS 231 as evidence of the Regional Center's determination that the Member meets the ICF/DD Home level of care.

10. Both AAH and the ICF/DD Homes follow the Medi-Cal Provider Manual and statutory and regulatory requirements related to LTC services for ICF/DD Home service. Whenever a reauthorization of ICF/DD-N Home services is requested, the ICF/DD-N Home submits a copy of the Member's ISP. ISP submissions are required as part of the periodic review of ICF/DD-N Homes. In instances where the Member is being discharged from or transferred out of an ICF/DD Home, the new ICF/DD Home must submit an updated authorization request that includes the changed dates of service.

11. The Alliance may decide, at its discretion, to perform an on-site level of care review of an LTC ARF. This review shall include an assessment of the Member and review of the medical orders, care plan, therapist treatment plan, the facility's multidisciplinary team notes, or other clinical data to assist the Alliance staff in making an appropriate determination on the authorization request.

12. Requests for reauthorization should be submitted to the Alliance LTC Department at least twenty-four (24) hours prior to the expiration of the active LTC/ ICF/DD/ SA/PSA Authorization. The facility may submit a reauthorizationARF up to sixty (60) calendar days prior to the expiration of the activeARF. The requests shall include a completedARF signed by a physician, (for NFs the most recent Quarterly Assessment MDS,) and sufficient documentation to justify the level of care and continued stay.

13. The Alliance shall be responsible for ensuring the provision of a Member's medical needs, supports, and services throughout the post-discharge and transition to community-based care period. The discharge planning may include, but is not limited to:

a. Documentation of pre-admission, or baseline, status.
b. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification, and integration of community based LTC programs.
c. Initial coordination of care, as appropriate with the Member's caregiver, other agencies, and knowledgeable personnel, as well as ensuring the Member's care coordinator contact information for hospitals; and
d. Provision of information for making follow-up appointments.

14. The Alliance shall be responsible for ensuring that all Medically Necessary services are provided in a timely manner upon discharge, and that a Member's transition to the most appropriate level of care and community-based care occurs, from the NF/ICF/DD Home/SA/PSA, to meet the Member's medical and social needs.

PROCEDURE

1. The Alliance shall utilize the DHCS standard clinical criteria in the LTC ARF adjudication process as stated in the Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services.

2. The ARF request is initiated by the facility and must be signed by the attending physician.

3. If theARF and required documents are incomplete, the Alliance LTC Department shall defer and return the incompleteARF and attachments to the facility for review and resubmission with additional clinical documents. The Alliance LTC Department will send the facility a "NOA Delay" letter within twenty-four (24) hours of decision to delay. The facility shall resubmit theARF within fourteen (14) calendar days after the submission of the initialAuthorization Request (AR) or theAR shall be subject to denial.

4. If the Alliance's LTC Department is unable to approve the AR due to insufficient documentation of Medical Necessity, the Alliance LTC Department shall submit the ARF and accompanying documentation to the Alliance Medical Director, or authorized physician designee, for review and determination.

    a. If the Alliance's Medical Director, or physician designee, approves the AR, the Alliance LTC Department shall send a copy of the approved Authorization to the facility.
    b. If the Alliance's Medical Director, or physician designee, denies or modifies the AR, the Alliance LTC Department shall notify the facility, the Member, or the Member's Authorized Representative in accordance with the Alliance UM Policies.

5. The Alliance LTC Department shall provide Members and Providers with a written Notice of Action, as appropriate, for any decisions to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

6. Upon receipt of an ARF modification, or denial, the facility shall have the ability to file an appeal, or complaint, in accordance with the Alliance G&A Policies.

7. Upon notification by a facility of a Member's discharge, the Alliance LTC Department shall close the active ARF effective the day of discharge. The facility shall notify the Alliance within one (1) business day of a Member's discharge by sending the Discharge Disposition Form to the LTC Department and submitting a completed

Medi-Cal LTC Facility Discharge Notification Form (MC171) to the appropriate agency. The Alliance LTC Department shall notify the appropriate departments for further care coordination.

DEFINITIONS / ACRONYMS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions (example: 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)** is a physician or other health professional who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse facility and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical arear of practice.

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.

E. **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.

F. **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.

G. **Intermediate Care Facilities/Developmental Disability (ICF/DD**) provides care for members with a developmental disability with complex medical problems requiring skilled care or observation on an ongoing intermittent basis and 24 hour supervision. Criteria for Subacute Services is in section 7.3 and 7.4 of the Medical Provider Manual.

H. **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.

I. **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. [2013 Group Care Program EOC, page 90)

J. **Medically Necessary (Medi-Cal Program):** means 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.

K. **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 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.

L. **Member** means any eligible beneficiary who has enrolled in the AAH and who has been assigned to or selected a Plan.

M. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and public reporting on the quality of health plans and other health care entities.

N. **Non-Contracted Provider** is a provider of health care services who is not contractually affiliated with AAH.

O. **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.

P. **Post Service or Retrospective** is defined as utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

Q. **Prior Authorization**: A type of Organization Determination that occurs prior to services being rendered.

R. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

S. 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.**Qualified Health Care Professional** is a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.

T. **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

U. **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

Long Term Care
Utilization Management
Grievance and Appeals Department
Claims Department
Case Management

RELATED POLICIES AND PROCEDURES

1. LTC 001 Long Term Care
2. LTC 003 Bed Hold and Leave of Absence
3. UM-054 Notice of Action
4. UM-057 Authorization Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

02/21/2023

REFERENCES

1. Department of Health Care Services (DHCS) and Alameda Alliance for Health Two Plan Model Contract
2. DHCS Single Plan Model Contract
3. Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services
4. Alliance Policy EE.1135: Long Term Care Facility Contracting
5. UM Policy 057- Authorization and Processing of Referrals
6. G&A Policy – Grievance and Appeals
7. Claims Policy – Provider Disputes Resolution
8. The Alliance Provider Manual
9. The Alliance Utilization Management Program
10. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements and Revised Notice Templates and Your Rights
11. DHCS All Plan Letter (APL) 22-032: Continuity of Care
12. DHCS (APL) 23-004 Skilled Nursing Facilities-Long Term Care Benefit Standardization and Transition of Members to Managed Care
13. DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities-LTC Benefit Standardization and Transition of Members to Managed Care
14. APL 23-027 Subacute Care Facilities- Long Term Care Benefit Standardization and Transition of Members to Managed Care
15. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
16. Title 22, California Code of Regulations (CCR), §§ 51120, 51121, 51124, 51215, 51118 and 51212
17. Welfare and Institutions (W&I) Code, §§ 14087.55, 14087.6, 14087.9, and 14103.6

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, including LTC.
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.
    b. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.

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Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	LTC -002
Policy Name	Authorization Process and Criteria for Admission ~~to~~, Continued Stay ~~in~~, and Discharge from a ~~Nursing~~ Long Term Care Facility ~~Level A (NF-A) and Level B (NF-B)~~
Department Name	Long Term Care
Department Officer	CMO
Policy Owner	Director of LTSS
Line(s) of Business	Medi-Cal
Effective Date	01/01/2023
Approval/Revision Date	~~02/21/2023~~TBD

POLICY STATEMENT

This policy outlines the requirements for reviewing and processing Long Term Care (LTC) Authorizations for a Member's admission to, continued stay in, or discharge from a Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B), Intermediate Care Facility-Developmental Disability (ICF/DD), Subacute Facilities (SA) and Pediatric Subacute Facilities (PSA).

POLICY

1. The Alliance's LTC Department shall process all requests for admission to, continued stay in, or discharge from a Nursing Facility (NF) Level A (NF-A) and/or Level B (NF-B) /ICF-DD/SA/PSA pursuant to the Department of Health Care Services (DHCS) standard clinical criteria in the Medi-Cal Manual of Criteria, Chapter 7, Criteria for Long Term Care Services. ~~B.~~
2. **Skilled Nursing Facility Level of Care** means that level of care provided by a skilled nursing facility meeting the standards of participation as a Medi-Cal program set forth in section CCR 51215 and CCR 51335(j).
    a. The skilled nursing facility level of care is the level of care needed by Medi-Cal beneficiaries who do not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care, but who require the continuous availability of skilled nursing care provided by licensed registered or vocational nurses, or the equivalent thereof.
    b. Skilled nursing care provided in participating skilled nursing facilities is the composite of necessary observation, assessment, judgment, supervision,

documentation, and teaching of the patient and includes specific tasks and procedures.

c. Skilled nursing procedures provided as a part of skilled nursing care are furnished under the direction of a registered nurse in response to the attending physician's orders, and are either performed or supervised by a licensed registered nurse, a licensed vocational nurse or in the case of institutions for persons with developmental disabilities or distinct parts of institutions which are certified as skilled nursing facilities and providing care for persons with developmental disabilities, by a licensed psychiatric technician. A need for one or more skilled nursing procedures does not necessarily indicate a medical need for skilled nursing facility services. Rather, the need must be for a level of service which includes the continuous availability of procedures such as, but not necessarily limited to, the following: administration of intravenous, intramuscular, or subcutaneous injections, and intravenous or subcutaneous infusions; gastric tube or gastrostomy feedings; nasopharygeal aspiration; insertion or replacement of catheters; application of dressings involving prescribed medications and aseptic techniques; treatment of extensive decubiti and other widespread skin disorders; heat treatments which require observation by licensed personnel to evaluate the patient's progress; administration of medical gases under prescribed therapeutic regimen; and restorative nursing procedures which require the presence of a licensed nurse.

d. Other health care services, such as physical, occupational or speech therapy, require specialized training for proper performance. The need for such therapies does not necessarily indicate a need for nursing facility services.

3. **Intermediate Care Facilities (ICF-DD):** Effective January 1, 2024, AAH will provide all medically necessary covered services for Members residing in or obtaining care in an ICF/DD Home/SA/PSA, including home services, professional services, ancillary services, transportation services and the appropriate level of care coordination, as outlined in APL 23-023, the contract with DHCS, and the Population Health Policy Guide.

AAH authorizes and covers medically necessary ICF/DD Home services, consistent with definitions in the Medi-Cal Provider Manual. AAH ensures Members in need of ICF/DD Home services, as determined through the IPP and Regional Center authorization, are authorized using the Certification for Special Treatment Program Services form HS 231. Under continuity of care requirements, AAH must receive a copy of the Certification for Special Treatment Program Services form HS 231 as a prerequisite to providing coverage of ICF/DD Home services. 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.

4. **Subacute Facilities (SA):** Effective January 1, 2024, AAH will provide all medically necessary covered services for Members residing in or obtaining care in Subacute

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Facilities. Subacute Level of Care means a level of care needed by a member who does not require hospital acute care, but who requires more intensive licensed skilled care than is provided to most patients in a skilled nursing facility

a. To be eligible for subacute level of care a patient's condition shall meet all the criteria as provided for in the Subacute Level of Care Criteria contained in the Manual of Criteria for Medi-Cal Authorization referenced in Title 22, California Code of Regulations (CCR), Section Title 22, California Code of Regulations (CCR), Section 51003(e)as determined by the patient's attending physician

5. **Pediatric Subacute Facilities (PSA):** Effective January 1, 2024, AAH will provide all medically necessary covered services for Members residing in or obtaining care in Pediatric Subacute Care Facilities. Pediatric Subacute 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.

a. Medical necessity for pediatric subacute services is substantiated by any one of the following items in (1) through (4) below:

(1) A tracheostomy with dependence on mechanical ventilation for a minimum of six hours each day;

(2) Dependence on tracheostomy care requiring suctioning at least every six hours, and room air mist or oxygen as needed, and dependence on one of the four treatment procedures listed in (B) through (E) below:

(A) Dependence on intermittent suctioning at least every eight hours, and room air mist or oxygen as needed;

(B) Dependence on continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent, via a peripheral or central line, without continuous infusion;

(C) Dependence on peritoneal dialysis treatments requiring at least four exchanges every 24 hours;

(D) Dependence on tube feeding, naso-gastric or gastrostomy tube;

(E) Dependence on other medical technologies is required continuously, which in the opinion of the attending physician, require the services of a professional nurse.

(3) Dependence on total parenteral nutrition or other intravenous nutritional support, and dependence on one of the five treatment procedures listed in (b)(2)(A) through (E) above;

(4) Dependence on skilled nursing care in the administration of any three of the five treatment procedures listed in (a)(2)(A) through (E) above.

b. Medical necessity for pediatric skilled nursing care will also be substantiated by all of the following:

i. The intensity of medical/skilled nursing care required by the patient shall be such that the continuous availability of a registered nurse in the

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pediatric subacute unit is medically necessary to meet the patient's healthcare needs, and not be any less than the nursing staff ratios specified in CCR Section 51215.8(g) and (i);

ii. The patient's medical condition has stabilized such that the immediate availability of the services of an acute care hospital, including daily physician visits, are not medically necessary:

~~1.~~iii. The intensity of medical/skilled nursing care required by the patient is such that, in the absence of a facility providing pediatric subacute care services, the only other medically necessary inpatient care appropriate to meet the patient's health care needs under the Medi-Cal program is in an acute care licensed hospital bed

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~~2.~~6. For a non-contracted facility requesting authorization for services, the Alliance shall verify that the facility:

a. Is licensed by the California Department of Public Health (CDPH);
b. Meets acceptable quality standards; and
c. Agrees to the Alliance rates, in accordance with the established Alliance Contract
   i. A non-contracted facility shall provide the required documentation to the Alliance for Credentialing purposes.

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~~i.~~7. AAH coordinates benefits with Other Healthcare Coverage (OHC) programs or entitlements in accordance with APL 22-027, Cost Avoidance and Post-Payment Recovery for Other Health Coverage, or any superseding APL. Such coordination of benefits includes recognizing OHC as primary and the Medi-Cal program as the payer of last resort by exercising cost avoidance and conducting post-payment recovery. Members may still utilize their OHC after enrollment in AAH. OHC providers do not have to be in the AAH Network to continue providing services or billing AAH for copays. For Members who are dually Medicare and Medi-Cal covered, or who have OHC, AAH coordinates care and addresses coverage needs, regardless of payer source. Members may receive other benefits from Medicare in addition to the ICF/DD Home benefits that fall to AAH to coordinate.

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8. ~~A~~ LTC facilities will~~facility shall~~ submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) or the Intermediate Care Facility (ICF) Authorization Request Form ~~(Sections I through IV).~~

   a. In addition, NF-A or NF-B facilities will also submit the ~~,~~
      i. Minimum Data Set (MDS),
      ii. Preadmission Screening and Resident Review, (PASRR~~,~~) if the member failed the first screen and
      ~~–~~Provider Utilization Committee Determination (Medicare or other insurance denial) ~~as~~ if appropriate

~~3.b. within twenty-one (21) calendar days from the start date of the Alliance LTC coverage.~~

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9. AAH ensures that timely access to the NF/ICF/DD Home/SA/PSA benefit is available within five to no more than 14 calendar days of receiving the authorization request from the NF/ICF/DD Home/SA/PSA, as outlined in Welfare and Institutions Code (W&I) section 14197. AAH expedites prior authorization requests for Members who are transitioning from an acute care hospital to a NF/ICF-DD/SA/PSA facility. AAH makes all authorization decisions in a timeframe appropriate for the nature of the Member's condition, and all authorization decisions are made within 72 hours after AAH receives relevant information needed to make an authorization decision

    a. ICF/DD Homes will submit the Certification for Special Treatment Program Services form HS 231 to AAH with any initial or reauthorization requests. AAH will accept the Certification for Special Treatment Program Services form HS 231 as evidence of the Regional Center's determination that the Member meets the ICF/DD Home level of care.

10. Both AAH and the ICF/DD Homes follow the Medi-Cal Provider Manual and statutory and regulatory requirements related to LTC services for ICF/DD Home service. Whenever a reauthorization of ICF/DD-N Home services is requested, the ICF/DD-N Home submits a copy of the Member's ISP. ISP submissions are required as part of the periodic review of ICF/DD-N Homes. In instances where the Member is being discharged from or transferred out of an ICF/DD Home, the new ICF/DD Home must submit an updated authorization request that includes the changed dates of service.

~~4.~~11. The Alliance may decide, at its discretion, to perform an on-site level of care review of an LTC ARF. This review shall include an assessment of the Member and review of the medical orders, care plan, therapist treatment plan, the facility's multidisciplinary team notes, or other clinical data to assist the Alliance staff in making an appropriate determination on the authorization request.

~~5.~~12. Requests for ~~The facility shall submit a~~ reauthorization ~~of an LTC ARF~~should be submitted to the Alliance LTC Department at least twenty-four (24) hours prior to the expiration of the active LTC/ ICF/DD/ SA/PSA Authorization ~~ARF~~. The facility may submit a reauthorization ~~LTC~~ ARF up to sixty (60) calendar days prior to the expiration of the active ~~LTC~~ ARF. The requests shall include a completed ~~LTC~~ ARF signed by a physician, (for NFs the most recent Quarterly Assessment MDS,) and sufficient documentation to justify the level of care and continued stay.

~~6.~~13. The Alliance shall be responsible for ensuring the provision of a Member's medical needs, supports, and services throughout the post-discharge and transition to community-based care period. The discharge planning may include, but is not limited to:

    a. Documentation of pre-admission, or baseline, status.
    b. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification, and integration of community based LTC programs.

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c. Initial coordination of care, as appropriate with the Member's caregiver, other agencies, and knowledgeable personnel, as well as ensuring the Member's care coordinator contact information for hospitals; and
d. Provision of information for making follow-up appointments.

~~7.~~14. The Alliance shall be responsible for ensuring that all Medically Necessary services are provided in a timely manner upon discharge, and that a Member's transition to the most appropriate level of care and community-based care occurs, from the NF/ICF/DD Home/SA/PSA, to meet the Member's medical and social needs.

PROCEDURE

1. The Alliance shall utilize the DHCS standard clinical criteria in the LTC ARF adjudication process as stated in the Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services.

2. The ~~LTC~~ ARF request is initiated by the facility and must be signed by the attending physician.

3. If the ~~LTC~~ ARF and required documents are incomplete, the Alliance LTC Department shall defer and return the incomplete ~~LTC~~ ARF and attachments to the facility for review and resubmission with additional clinical documents. The Alliance LTC Department will send the facility a "NOA Delay" letter within twenty-four (24) hours of decision to delay. The facility shall resubmit the ~~LTC~~ ARF within fourteen (14) calendar days after the submission of the initial~~l LTC~~ Authorization Request (AR) ~~ARF~~ or the ~~LTC~~ AR~~F~~ shall be subject to denial.

4. If the Alliance's LTC Department is unable to approve the AR~~F~~ due to insufficient documentation of Medical Necessity, the Alliance LTC Department shall submit the ~~LTC~~ ARF and accompanying documentation to the Alliance Medical Director, or authorized physician designee, for review and determination.

   a. If the Alliance's Medical Director, or physician designee, approves the ~~LTC~~ AR~~F~~, the Alliance LTC Department shall send a copy of the approved ~~LTC~~ Authorization~~RF~~ to the facility.
   b. If the Alliance's Medical Director, or physician designee, denies or modifies the ~~LTC~~ AR~~F~~, the Alliance LTC Department shall notify the facility, the Member, or the Member's Authorized Representative in accordance with the Alliance UM Policies.

~~5. If the facility submits a complete LTC ARF within the twenty-one (21) calendar day submission period, the Alliance shall approve the LTC ARF retroactive to the date of the admission.~~

~~6.~~5. The Alliance LTC Department shall provide Members and Providers with a written Notice of Action, as appropriate, for any decisions to deny a service authorization

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request, or to authorize a service in an amount, duration, or scope that is less than requested.

~~7.~~6. Upon receipt of an ~~LTC~~ ARF modification, or denial, the facility shall have the ability to file an appeal, or complaint, in accordance with the Alliance G&A Policies.

~~8.~~7. Upon notification by a facility of a Member's discharge, the Alliance LTC Department shall close the active ~~LTC~~ ARF effective the day of discharge. The facility shall notify the Alliance within one (1) business day of a Member's discharge by sending the Discharge Disposition Form to the LTC Department and submitting a completed Medi-Cal LTC Facility Discharge Notification Form (MC171) to the appropriate agency. The Alliance LTC Department shall notify the appropriate departments for further care coordination.

DEFINITIONS / ACRONYMS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions (example: 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)** is a physician or other health professional who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse facility and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical arear of practice.

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.

E. **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.

F. **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.

~~F.~~G. **Intermediate Care Facilities/Developmental Disability (ICF/DD)** provides care for members with a developmental disability with complex medical problems requiring skilled care or observation on an ongoing intermittent basis and 24 hour supervision. Criteria for Subacute Services is in

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section 7.3 and 7.4 of the Medical Provider Manual.

~~G.~~H. **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.

~~H.~~I. **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. [2013 Group Care Program EOC, page 90)

~~I.~~J. **Medically Necessary (Medi-Cal Program):** means 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.

~~J.~~K. **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 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.

~~K.~~L. **Member** means any eligible beneficiary who has enrolled in the AAH and who has been assigned to or selected a Plan.

~~L.~~M. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and public reporting on the quality of health plans and other health care entities.

N. **Non-Contracted Provider** is a provider of health care services who is not contractually affiliated with AAH.

O. **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.

~~M.~~

~~N.~~P. **Post Service or Retrospective** is defined as utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

~~O.~~Q. **Prior Authorization**: A type of Organization Determination that occurs prior to services being rendered.

~~P.~~R. **Provider** means 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~~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.

S. **Qualified Health Care Professional** is a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.

T. **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

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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

~~Q.~~

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~~R.~~U. **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

Long Term Care
Utilization Management
Grievance and Appeals Department
Claims Department
Case Management

RELATED POLICIES AND PROCEDURES

1. LTC 001 Long Term Care
~~1.~~2.LTC 003 Bed Hold and Leave of Absence
~~2.~~3.UM-054 Notice of Action
~~3.~~4.UM-057 Authorization Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

02/21/2023

REFERENCES

1. Department of Health Care Services (DHCS) and Alameda Alliance for Health Two Plan Model Contract

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~~1.~~2.DHCS Single Plan Model Contract
~~2.~~3.Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services
~~3.~~4.Alliance Policy EE.1135: Long Term Care Facility Contracting
~~4.~~5.UM Policy 057- Authorization and Processing of Referrals
~~5.~~6.~~AGD~~ G&A Policy – Grievance and Appeals
~~6.~~7.Claims Policy – Provider Disputes Resolution
~~7.~~8.The Alliance Provider Manual
~~8.~~9.The Alliance Utilization Management Program

~~9.~~10. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~17-006~~21-011: Grievance and Appeal Requirements and Revised Notice Templates and Your Rights

~~10.~~11. DHCS~~Department of Health Care Services~~ All Plan Letter (APL) ~~14-004~~22-032: Continuity of Care

12. ~~Department of Health Care Services~~DHCS ~~All Plan Letter~~ (APL) ~~16-003: Long Term Care~~23-004 Skilled Nursing Facilities-Long Term Care Benefit Standardization and Transition of Members to Managed Care

13. DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities-LTC Benefit Standardization and Transition of Members to Managed Care

14. ~~DRAFT~~ APL 23-027~~XXX~~ Subacute Care Facilities- Long Term Care~~TC~~ Benefit Standardization and Transition of Members to Managed Care

~~11.~~

~~12.~~15. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division

~~13.~~16. Title 22, California Code of Regulations (CCR), §§ 51120, 51121, 51124, 51215, 51118 and 51212

~~14.~~17. Welfare and Institutions (W&I) Code, §§ 14087.55, 14087.6, 14087.9, and 14103.6

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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, including LTC.
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.
   b. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.

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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	Manager, LTC
Line(s) of Business	Medi-Cal
Effective Date	1/1/2023
Approval/Revision Date	~~02/21/2023~~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. Long Term Care (LTC) facilities is inclusive of Skilled Nursing Facilities (SNFs) Nursing Facilities (NF), Intermediate Care Facilities (ICFs), Subacute Facilities (SA) and Pediatric Subacute Facilities (PSA).

A Bed Hold occurs when a Member residing in a ~~nursing~~ LTC facility is admitted to an acute care hospital and the Member is expected to return to the LTC facility upon discharge from the acute hospital. AAH will provide continuity of care for Members that are transferred from a ~~SNF~~LTC to a general acute care hospital, and then require a return to a ~~SNF~~LTC level of care due to medical necessity. For members residing in ICF-DDs, AAH covers the stay and provides continuity of care when Members transfer from an ICF/DD Home to any acute care hospital setting, a post-acute care setting such as a skilled nursing facility (SNF), or a rehabilitation facility, and then require a return to an ICF/DD Home. AAH includes as a covered benefit any LOA or bed hold that an ICF/DD Home provides.

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 ~~SNF~~LTCs

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 ~~SNF~~LTCs upon request by visiting the AAH website or Provider Portal.

B. ~~SNF~~LTC Required Communication with Member or Member's Authorized Representative

1. ~~SNF~~LTCs 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~~LTC refuses to readmit the Member after an admission the ~~SNF~~LTC 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~~ LTC facility is admitted to an acute care hospital the ~~SN~~LTC 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 open LTC authorization with new skill level and enter bed hold revenue code.
        a. Facilities should utilize the LTC authorization request form and/or discharge disposition form to notify AAH.
    b. LTC-UM will process inpatient authorization for acute hospital admission.
        I. LTC-UM will notify inpatient facility of authorization status
        II. LTC-UM will process all concurrent reviews during acute hospital admission bed hold time frame.
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~~Long Term Care Facility (~~SNF~~LTC) that the Member requires more than seven days of hospital care at which time the ~~Skilled Nursing~~LTC Facility (~~SNF~~LTC) will notify AAH. If notified in writing by attending physician the patient requires more than seven (7) days of hospitalization, the long-term care facilities are not required to hold the bed.

d.
e.
f.
~~e.~~g.

i. LTC UM will close ~~SNF~~LTC authorization once BH is exhausted if the member is discharged from their LTC Facility.
ii. IP UM will continue to process all concurrent reviews until which time the Member is discharged to a ~~SNF~~LTC 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.
        iii. Seventy-three days per calendar year for developmentally disabled recipients.
        iv. 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~~LTC Facilities.
    b. Provisions for LOAs are part of the individual program plan for recipients in an ~~ICF/DD, ICF/DD-H or ICF/DD-N~~ICF-DD/SA/PSA 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~~LTC facility must show the address of the intended leave destination and inclusive dates of leave.
f. For all ~~NF-A and NF-B~~NF/SA/PSA recipients, including the mentally disabled, the provider is paid the appropriate ~~NF-A and NF-B~~NF/SA/PSA 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 ~~SN~~LTC 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~~LTC 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)

*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, the recipient's attendance must be prescribed by a licensed physician and approved by the appropriate regional center for the developmentally disabled.

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.
    ~~Recipient's attendance at camp is prescribed by a licensed physician and approved by an appropriate regional center for the developmentally disabled.~~
    a. Physician signature required for LOA only when member participates in summer camp 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~~ LTC 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~~LTC 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 dies 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 skilled 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.

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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~~ Long Term Care 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

02/21/2023

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
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) 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
DRAFT APL 23-XXX Subacute Care Facilities- LTC Benefit Standardization and Transition of Members to Managed Care

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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 Health Care Quality 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	Manager, LTC
Line(s) of Business	Medi-Cal
Effective Date	1/1/2023
Approval/Revision Date	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. Long Term Care (LTC) facilities is inclusive of Skilled Nursing Facilities (SNFs) Nursing Facilities (NF), Intermediate Care Facilities (ICFs), Subacute Facilities (SA) and Pediatric Subacute Facilities (PSA).

A Bed Hold occurs when a Member residing in a LTC facility is admitted to an acute care hospital and the Member is expected to return to the LTC facility upon discharge from the acute hospital. AAH will provide continuity of care for Members that are transferred from a LTC to a general acute care hospital, and then require a return to a LTC level of care due to medical necessity. For members residing in ICF-DDs, AAH covers the stay and provides continuity of care when Members transfer from an ICF/DD Home to any acute care hospital setting, a post-acute care setting such as a skilled nursing facility (SNF), or a rehabilitation facility, and then require a return to an ICF/DD Home. AAH includes as a covered benefit any LOA or bed hold that an ICF/DD Home provides.

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 LTCs

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 LTCs upon request by visiting the AAH website or Provider Portal.

B. LTC Required Communication with Member or Member's Authorized Representative

1. LTCs 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 LTC refuses to readmit the Member after admission the LTC 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 LTC facility is admitted to an acute care hospital the LTC 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 open LTC authorization with new skill level and enter bed hold revenue code.
        a. Facilities should utilize the LTC authorization request form and/or discharge disposition form to notify AAH.
    b. LTC-UM will process inpatient authorization for acute hospital admission.
        I. LTC-UM will notify inpatient facility of authorization status
        II. LTC-UM will process all concurrent reviews during acute hospital admission bed hold time frame.
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 Long-Term Care Facility (LTC) that the Member requires more than seven days of hospital care at which time the LTC Facility (LTC) will notify AAH. If notified in writing by attending physician the patient requires more than seven (7) days of hospitalization, the long-term care facilities are not required to hold the bed.

i. LTC UM will close LTC authorization once BH is exhausted if the member is discharged from their LTC Facility.
ii. IP UM will continue to process all concurrent reviews until which time the Member is discharged to a LTC 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.
        iii. Seventy-three days per calendar year for developmentally disabled recipients.
        iv. 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 LTC Facilities.
    b. Provisions for LOAs are part of the individual program plan for recipients in an ICF-DD/SA/PSA 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 LTC facility must show the address of the intended leave destination and inclusive dates of leave.
f. For all NF/SA/PSA recipients, including the mentally disabled, the provider is paid the appropriate NF/SA/PSA 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 LTC 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 LTC 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)

*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, the recipient's attendance must be prescribed by a licensed physician and approved by the appropriate regional center for the developmentally disabled.
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. Physician signature required for LOA only when member participates in summer camp 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 LTC 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 LTC 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 dies 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 skilled 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-004 LTC Bed Hold and Leave of Absence

LTC-001 – Long Term Care Program
LTC-002 - Authorization Process and Criteria for Admission, Continued Stay, and Discharge from a Long-Term Care Facility
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

02/21/2023

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
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) 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
DRAFT APL 23-XXX Subacute Care Facilities- LTC 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 Health Care Quality Committee annually

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	PH-001
Policy Name	Population Health Management (PHM) Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Care and Group Care
Effective Date	9/19/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) maintains a Population Health Management (PHM) Program. The Alliance PHM Program aims to:

1. Ensure all members have equitable access to necessary wellness and prevention services, care coordination and care management.
2. Assess each member's needs across the continuum of care based on member preferences, data-driven risk stratification, identified gaps in care and standardized assessment processes.
3. Improve the health outcomes of all members.

The Alliance monitors its PHM Program to gain an internal understanding of the impact on quality and equity for groups serviced by the interventions.

The Alliance PHM Program meets all National Committee for Quality Assurance (NCQA) PHM standards as well as applicable federal and state requirements. The program complies with the California Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, the DHCS 2024 Managed Care Plan (MCP) Contract, or superseding DHCS policy guide and/or amended contract.

The Alliance PHM Program follows the DHCS Policy Guide Framework including the following four domains:

1. Population Health Management Strategy
2. Population Needs Assessment

3. Gathering member information and understanding risk
4. Providing supports and services

PROCEDURE

1. The Alliance maintains full NCQA Health Plan Accreditation which includes the PHM standards.
   1.1. The Alliance will obtain NCQA Health Equity Accreditation by Jan 1, 2026.
2. The Alliance PHM Program includes the following components:
   2.1. PHM Strategy and Population Needs Assessment (PNA)
      2.1.1. The Alliance develops an annual NCQA population assessment and PHM Strategy.
      2.1.2. The PNA requirement is met through meaningful participation in Alameda County's and the City of Berkeley's Community Health Assessment/Community Health Improvement Plan (CHA/CHIP), which are conducted on a three-year cycle. The Alliance submits an annual PNA and PHM Strategy deliverable to DHCS in October. (See *PHM-005 Population Assessment*)

   2.2. Gathering member information through screenings and assessments
      2.2.1. The Alliance conducts necessary screening and assessments to gain timely information on the health and social needs of all members, in accordance with applicable state and federal laws and regulations and NCQA PHM standards. For implementation and monitoring details, see *QI-124 IHA Policy* and *CM-020 Health Information Form/Member Evaluation Tool (HIF/MET).*
      2.2.2. The Alliance contracts with providers to conduct assessments and integrate the results with care and care management processes.
      2.2.3. The following populations are assessed:
         2.2.3.1. Those with long-term services and supports (LTSS) needs (See *CM-008 SPD HRA - Survey and Interventions*)
         2.2.3.2. Those entering Complex Case Management (CCM) (See *CM-001 CCM Identification Screening Enrollment and Assessment*)
         2.2.3.3. Those entering Enhanced Care Management (ECM) (See *CM-011 Enhanced Care Management - Care Management & Transitions of Care*).
         2.2.3.4. Children with Special Health Care Needs (CSHCN) (*UM-002 Coordination of Care*)
         2.2.3.5. Pregnant individuals (See *UM-025 Guidelines for Obstetrical Services*)
         2.2.3.6. Seniors and persons with disabilities who meet the definition of "high risk." (See *CM-008 SPD HRA - Survey and Interventions*)
         2.2.3.7. Members who are identified as high risk
            2.2.3.7.1. Prior to the DHCS PHM Service launch, the Alliance will use their own Risk Stratification and Segmentation (RSS) strategy.
            2.2.3.7.2. After the statewide RSS and risk tiers are available through the PHM Service, the Alliance will at minimum assess members who are identified as high-risk through the PHM Service.
         2.2.3.8. In addition, CSHCN and those with LTSS needs receive an annual reassessment.

2.2.4. The Alliance or contracted PCP follows up on any positive assessment results.

2.3. The Alliance leverages a broad set of data sources to support PHM Program information gathering and inform Risk Stratification and Segmentation (RSS) as described in Understanding risk (See *PH-003 Risk Stratification and Segmentation (RSS) Process*).

2.4. The Alliance provides members three types of services and supports:

2.4.1. Care management programs including:

2.4.1.1. ECM (See *CM-011 Enhanced Care Management*)

2.4.1.2. CCM (See *CM-001 CCM Identification Screening Enrollment and Assessment*)

2.4.2. Basic Population Health Management (BPHM*) (*See *PH-003 Basic Population Health Management (BPHM)*) which includes the following services:

2.4.2.1. Access to primary care

2.4.2.2. Care Coordination, navigation and referrals across health and social services

2.4.2.3. Information sharing

2.4.2.4. Services provided by Community Health Workers (CHWs)

2.4.2.5. Wellness and prevention programs

2.4.2.6. Chronic disease programs

2.4.2.7. Programs focused on improving maternal health outcomes

2.4.2.8. Case management services for children under EPSDT

2.4.3. Transitional Care Services (TCS) (See *CM-034 Transitional Care Services*)

3. The Alliance uses Quality Measures and Key Performance Indicators (KPIs) to assess the overall implementation, operations, and effectiveness of all PHM programs and understand the impact on quality and equity.

3.1. Areas that are monitored include, but are not limited to BPHM, ECM, CCM, and TCS.

3.2. Quality Measures are reviewed annually based on DHCS guidance.

3.3. KPIs are developed based on DHCS guidance and monitored monthly with quarterly submissions to DHCS.

DEFINITIONS / ACRONYMS

BPHM – Basic Population Health Management means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

CHA – Community Health Assessment means a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. Public health departments such as State, local, territorial, or Tribal develop CHAs to meet voluntary Public Health Accreditation Board (PHAB) standards and State Future of Public Health funding requirements. A variety of tools and processes may be used to conduct these population-level assessments. The essential feature, as defined by the PHAB, is that the assessment is developed through a participatory, collaborative process with various key sectors of the community.

CHIP – Community Health Improvement Plan means the output of the CHA when produced by public health departments (local, territorial, State, or Tribal) for PHAB accreditation, State Local Assistance Spending Plan funding allocation, and non-profit hospitals to meet federal and State requirements.
CSHCN – Children with Special Health Care Needs
CCM – Complex Case Management
CHW – Community Health Worker means an individual known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in All Plan Letter (APL) 22-016 or superseding APL.
DHCS - California Department of Health Care Services
ECM – Enhanced Care Management means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
EPSDT - Early and Periodic Screening, Diagnostic, and Treatment (also known as Medi-Cal for Teens and Kids) means the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC sections 1396a(a)(43) and 1396d(a)(4)(B) and (r), 42 CFR section 441.50 *et seq*., and as required by W&I sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or Behavioral Health conditions.
IHA – Initial Health Appointment means an assessment that must be completed within 120 days of MCP enrollment for new Members and must include a history of the Member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and a diagnosis and plan for treatment of any diseases.
KPI – Key Performance Indicators
LHD – Local Health Department means a municipal, county, or regional public health department**.**
LTSS – Long-term Services and Supports means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS Programs, and includes carved-in and carved-out services.
MCP – Managed Care Plan
NCQA – National Committee for Quality Assurance
PCP – Primary Care Provider means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.
PHM – Population Health Management means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses

member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.
PHM Service – Population Health Management Services means a service that collects and links Medi-Cal beneficiary information from disparate sources and performs RSS and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.
PHM Strategy – means an annual deliverable that the Alliance must submit to DHCS requiring the Alliance to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.
PNA – Population Needs Assessment means a multi-year process during which the Alliance will identify and respond to the needs of its members and the communities it serves by participating in the CHA of LHDs in its Service Area. The findings of the PNA/CHA collaboration will inform the Alliance's annual PHM Strategy.
RSS – Risk Stratification and Segmentation
TCS – Transitional Care Services

AFFECTED DEPARTMENTS/PARTIES

Analytics
Case Management
Health Care Services
Member Services
Population Health and Equity
Provider Services
Quality Improvement
Alliance Provider Network
Alliance local health and community-based organizations

RELATED POLICIES AND PROCEDURES

CM-001 CCM Identification Screening Enrollment and Assessment
CM-008 SPD HRA - Survey and Interventions
CM-011 Enhanced Care Management - Care Management & Transitions of Care
CM-020 Health Information Form/Member Evaluation Tool (HIF/MET)
CM-034 Transitional Care Services
PH-002 Basic Population Health Management (BPHM)
PH-003 Risk Stratification and Segmentation (RSS) Process
PH-005 Population Assessment
QI-124 IHA Policy
UM-002 Coordination of Care
UM-025 Guidelines for Obstetrical Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy 9/19/2023, TBD

REFERENCES

DHCS CalAIM: Population Health Management (PHM) Policy Guide
DHCS 2023 MCP Amended Contract
DHCS 2024 MCP Contract

MONITORING

This Policy will be reviewed annually.

POLICY AND PROCEDURE

Policy Number	PH-001
Policy Name	Population Health Management (PHM) Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Care and Group Care
Effective Date	9/19/2023
Subcommittee Name	~~Health Care Quality~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/18/2023~~TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

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2. Assess each member's needs across the continuum of care based on member preferences, data-driven risk stratification, identified gaps in care and standardized assessment processes.
3. Improve the health outcomes of all members.

The Alliance monitors its PHM Program to gain an internal understanding of the impact on quality and equity for groups serviced by the interventions.

The Alliance PHM Program meets all National Committee for Quality Assurance (NCQA) PHM standards as well as applicable federal and state requirements. The program complies with the California Department of Health Care Services (DHCS) ~~All Plan Letter 22-024 Population Health Management Program Guide~~CalAIM: Population Health Management (PHM) Policy Guide, ~~the Amended DHCS 2023 Managed Care Plan (MCP) contract,~~ the DHCS 2024 Managed Care Plan (MCP) Contract, or superseding DHCS policy guide and/or amended contract.

The Alliance PHM Program follows the DHCS ~~Program~~ Policy Guide Framework including the following four domains:

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4. Providing supports and services

PROCEDURE

1. The Alliance maintains full NCQA Health Plan Accreditation which includes the PHM standards.
   1.1. The Alliance will obtain NCQA Health Equity Accreditation by Jan 1, 2026.
2. The Alliance PHM Program includes the following components:
   2.1. PHM Strategy and Population Needs Assessment (PNA)
      2.1.1. The Alliance develops an annual NCQA population assessment and PHM Strategy.
      2.1.2. The PNA requirement is met through meaningful participation in Alameda County's and the City of Berkeley's Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) ~~processes~~, which are conducted on a three-year cycle. The Alliance submits an annual PNA and PHM Strategy deliverable to DHCS in October. (See *PHM-005 Population Assessment*)
      ~~2.1.1. The Alliance will submit its first annual comprehensive PHM Strategy to DHCS in October 2023.~~
      ~~2.1.2. The Alliance PHM Strategy contains a special section focused on how the Alliance provides services to member less than 21 years of age, including but not limited to Basic PHM, EPSDT services, Care Coordination services, Early Intervention Services and a Wellness and Prevention Program.~~
      ~~2.1.3. The PNA includes information spanning the needs of the entire member population, including members less than 21 years of age, and is submitted every 3 years (see *HED-003 Population Needs Assessment*).~~
   2.2. Gathering member information through screenings and assessments
      2.2.1. The Alliance conducts necessary screening and assessments to gain timely information on the health and social needs of all members, in accordance with applicable state and federal laws and regulations and NCQA PHM standards. For implementation and monitoring details, see *QI-124 IHA Policy* and *CM-020 Health Information Form/Member Evaluation Tool (HIF/MET).*
      2.2.2. The Alliance contracts with providers to conduct assessments and integrate the results with care and care management processes.
      2.2.3. The following populations are assessed:
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2.2.3.4. Children with Special Health Care Needs (CSHCN) (*UM-002 Coordination of Care*)
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2.2.3.7.1. Prior to the DHCS PHM Service launch, the Alliance will use their own Risk Stratification and Segmentation (RSS) strategy.
2.2.3.7.2. After the statewide RSS and risk tiers are available through the PHM Service, the Alliance will at minimum assess members who are identified as high-risk through the PHM Service.
2.2.3.8. In addition, CSHCN and those with LTSS needs receive an annual reassessment.
2.2.4. The Alliance or contracted PCP follows~~-~~ up on any positive assessment results ~~to complete the follow-up~~.
2.3. The Alliance leverages a broad set of data sources to support PHM Program information gathering and inform Risk Stratification and Segmentation (RSS) as described in U~~u~~nderstanding risk (See *PH-003 Risk Stratification and Segmentation (RSS) Process*).
2.4. The Alliance provides members three types of services and supports:
2.4.1. Care management programs including:
2.4.1.1. ECM (See *CM-011 Enhanced Care Management*)
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2.4.2. Basic Population Health Management (BPHM*) (*See *PH-003 Basic Population Health Management (BPHM)*) which includes the following services:
2.4.2.1. Access to primary care
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2.4.2.3. Information sharing
2.4.2.4. Services provided by Community Health Workers (CHWs)
2.4.2.5. Wellness and prevention programs
2.4.2.6. Chronic disease programs
2.4.2.7. Programs focused on improving maternal health outcomes
2.4.2.8. Case management services for children under EPSDT
2.4.3. Transitional Care Services (TCS) (See *CM-034 Transitional Care Services*)

3. The Alliance uses ~~data~~ Quality Measures and Key Performance Indicators (KPIs) to ~~continuously assess the efficacy~~ assess the overall implementation, operations, and effectiveness of all PHM programs ~~to~~ and understand the impact on quality and equity.
3.1. ~~Programs~~ Areas that are monitored include, but are not limited to BPHM, ECM, CCM, and ~~wellness and prevention efforts~~TCS.
3.2. Quality Measures are reviewed annually based on DHCS guidance.
~~3.2.~~3.3. KPIs are developed based on DHCS guidance and monitored monthly ~~based on DHCS guidance~~with quarterly submissions to DHCS.

DEFINITIONS / ACRONYMS

BPHM – Basic Population Health Management means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

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DHCS - California Department of Health Care Services

ECM – Enhanced Care Management means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

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KPI – Key Performance Indicators

LHD – Local Health Department means a municipal, county, or regional public health department.

LTSS – Long-term Services and Supports means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the

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setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS Programs, and includes carved-in and carved-out services.

MCP – Managed Care Plan

NCQA – National Committee for Quality Assurance

PCP – Primary Care Provider means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

PHM – Population Health Management means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

PHM Service – ~~Statewide technology service designed to support PHM Program functions~~Population Health Management Services means a service that collects and links Medi-Cal beneficiary information from disparate sources and performs RSS and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.

PHM Strategy – means an annual deliverable that the Alliance must submit to DHCS requiring the Alliance to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

PNA – Population Needs Assessment means a multi-year process during which the Alliance will identify and respond to the needs of its members and the communities it serves by participating in the CHA of LHDs in its Service Area. The findings of the PNA/CHA collaboration will inform the Alliance's annual PHM Strategy.

RSS – Risk Stratification and Segmentation

TCS – Transitional Care Services

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AFFECTED DEPARTMENTS/PARTIES

Analytics
Case Management
Health Care Services
Member Services
Population Health and Equity
Provider Services
Quality Improvement
Alliance Provider Network
Alliance local health and community-based organizations

RELATED POLICIES AND PROCEDURES

CM-001 CCM Identification Screening Enrollment and Assessment
CM-008 SPD HRA - Survey and Interventions
CM-011 Enhanced Care Management - Care Management & Transitions of Care
CM-020 Health Information Form/Member Evaluation Tool (HIF/MET)
CM-034 Transitional Care Services
~~HED-003 Population Needs Assessment~~
PH-002 Basic Population Health Management (BPHM)
PH-003 Risk Stratification and Segmentation (RSS) Process
PH-005 Population Assessment
QI-124 IHA Policy
UM-002 Coordination of Care
UM-025 Guidelines for Obstetrical Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy 9/19/2023, TBD

REFERENCES

DHCS ~~DHCS All Plan Letter 22-024 Population Health Management Program Guide~~CalAIM: Population Health Management (PHM) Policy Guide
DHCS 2023 MCP Amended Contract
DHCS 2024 MCP Contract

MONITORING

This Policy will be reviewed annually.

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	PH-002
Policy Name	Basic Population Health Management (BPHM)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Care and Group Care
Effective Date	9/19/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) offers Basic Population Health Management (BPHM) as a part of its Population Health Management (PHM) Program. BPHM services include access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs) under the CHW benefit, wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children under Early and Periodic Screening, Diagnosis and Treatment (EPSDT, Medi-Cal for Kids & Teens).

All Alliance members receive BPHM, regardless of their level of need. BPHM services comply with the California Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, the DHCS 2024 MCP Contract, or superseding APL or Contract, or Contract amendment. Where applicable, BPHM services meet NCQA PHM standards and align with the DHCS Comprehensive Quality Strategy.

PROCEDURE

1. The Alliance ensures its members receive BPHM services.
   1.1. For members who are successfully engaged in primary care, the Alliance requires Primary Care Providers (PCPs) to be responsible for select care coordination and health education functions. For members who do not engage with a PCP, the Alliance assumes responsibility for provision of BPHM.

1.2. For members enrolled in Enhanced Care Management (ECM), the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of their care management.
1.3. For members who receive skilled nursing facility or other long term care services, BPHM services are provided by the facility physician or the member's assigned PCP. When additional care coordination is needed, Alliance Long Term Care team provides BPHM services.

2. The Alliance ensures that all members have access to and are utilizing primary care by:
   2.1. Identifying members who are not using primary care via utilization reports and enrollment data, which are stratified by race and ethnicity, and developing strategies to address utilization patterns.
   2.2. Ensuring members have appropriate, ongoing, and timely source of primary care to meet the member's needs.
   2.3. Ensuring members are engaged with their assigned PCPs. For members who have been assigned a PCP but have not yet engaged with the PCP (e.g., assigned but not seen or lost to follow-up), the Alliance in coordination with PCP partners outreaches to the member.
      2.3.1. Sharing outreach reports with delegates and PCPs on assigned members requiring outreach and education on the importance of outreach to engage members in care.
      2.3.2. Sharing reports with PCPs on which members are due an Initial Health Appointment.
      2.3.3. Monitoring HEDIS measures related to preventive health visits and screenings and addressing identified gaps.
   2.4. As needed, conducting member outreach to ensure connection with their PCP and BPHM services.
   2.5. Assisting members in making appointments, arranging transportation, and providing education on the importance of primary care or have not been seen within the last 12 months, particularly members less than 21 years of age.

3. The Alliance ensures child and youth members under 21 years of age receive EPSDT (Medi-Cal for Kids & Teens) services through their participation in BPHM, CCM, or ECM.
   3.1. Monitor utilization of preventive health visits and developmental screenings, including relevant HEDIS measures.
   3.2. Collaborate with community agencies and pediatric providers to address gaps in utilization through education, gap in care reports, and member incentives.
   3.3. Contact members through live calls and IVR who have gaps in care with reminders, education and assistance in scheduling needed visits.
   3.4. Track use of CHWs and BPHM care coordination efforts to ensure follow up and care coordination needs identified from screenings are delivered.
   3.5. Establish Ensure members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities
   3.6. Establish MOUs with First 5 programs and providers, WIC providers and every Local Education Agency (LEA) in Alameda County for school-based services to strengthen provision of EPSDT (Medi-Cal for Teens & Kids).

4. Alliance members may receive Care Coordination services and navigation and referrals across health and social services as needed. These services are described in Alliance Policy *UM-002 Coordination of Care*.

5. Alliance members are eligible for CHW services as described in Alliance policy *PH-004 Community Health Worker (CHW) Services.*

6. The Alliance offers comprehensive wellness and prevention programs that meet NCQA PHM standards, including the provision of evidence-based self-management tools, and align with the DHCS Comprehensive Quality Strategy's Clinical Focus Areas and Bold Goals. The Alliance offers all members wellness and prevention programs, in collaboration with Local Government Agencies (LGAs) as appropriate. The Alliance:
   6.1. Uses the Population Needs Assessment (PNA) to identify specific, proactive wellness initiatives and programs that address member needs and reports this annually as part of the PHM Strategy as described in Alliance policy *PH-005 Population Assessment*.
   6.2. Addresses the NCQA required areas:
      6.2.1. Healthy weight maintenance
      6.2.2. Smoking and tobacco use cessation
      6.2.3. Encouraging physical activity
      6.2.4. Healthy eating
      6.2.5. Managing stress
      6.2.6. Avoiding at-risk drinking
      6.2.7. Identifying depressive symptoms
   6.3. Offers evidence-based disease management programs that comply with PHM NCQA standards including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, identify members for engagement, and seek to close care gaps for members participating in these programs. Disease Management Programs are described in the Alliance policy *CM-005 Disease Management Programs*.
   6.4. Implements evidence-based initiatives to improve access to preventative health visits, developmental screenings, and services for members less than 21 years of age.
   6.5. Implements evidence-based initiatives to improve pregnancy outcomes for women, including through 12 months postpartum.
   6.6. Implements evidence-based initiatives to ensure adults have access to preventive care, as described in the DHCS contract and in compliance with all applicable state and federal laws.
   6.7. Monitors the provision of wellness and preventive services by PCPs as part of our Site Review process. See Alliance policy *QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS).*
   6.8. Develops health education materials, in a manner that meets Members' health education and cultural and linguistic needs. Health Education materials development is described in Alliance policy *HED-002 Health Education Materials.*
   6.9. Implements evidence-based initiatives that are aimed at helping Members set and achieve wellness goals.
   6.10. Submits wellness and prevention programs to DHCS for review and approval in a form and method prescribed by DHCS.

7. The Alliance continues to meet all requirements for pregnant individuals, including covering the provision of all medically necessary services for pregnant women, administering a comprehensive risk assessment tool comparable to the ACOG and CPSP standards, and providing appropriate follow-ups. Services for pregnant individuals are described in the Alliance Policy *UM-025 Guidelines for Obstetrical Services*.

8. The Alliance ensures members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities with whom the Alliance has or will have an executed MOU.

9. The Alliance provides the following services for members under 21:
   9.1. An Initial Health Appointment (IHA) within 120 calendar days of enrollment or within the AAP Bright Futures periodicity timeline for children ages 18 months and younger, whichever is sooner. (See *QI-124 IHA Policy*)
   9.2. Preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the AAP Bright Futures periodicity schedule, and immunizations specified by the Advisory Committee on Immunization Practices (ACIP) childhood immunization schedule. (See *QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services*).
   9.3. Ensures that all medically necessary services, including those that are not necessarily covered for adults, are provided as long as they could be Medicaid covered services. (See *QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services*).
   9.4. Coordinates health and social services for children between settings of care and across other MCPs and delivery systems. Specifically, MCPs must support children and their families in accessing medically necessary physical, behavioral, and dental health services, as well as social and educational services (See *UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens and Kids)*).

10. All BPHM services promote health equity and align with the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the U.S. Department of Health and Human Services that focus on the delivery of services in a culturally appropriate manner. The Alliance supports CLAS standards through its Cultural and Linguistic Services program (See *CLS-001 Cultural and Linguistic Services Program*).

11. The Alliance ensures non-duplication of BPHM services through documentation of participation in the Alliance Clinical Information System and reports that monitor member participation in BPHM services.

12. The Alliance does not fully delegate wellness and prevention programs to subcontractors or downstream subcontractors. However, the Alliance works with our delegated entities to ensure provision of wellness and prevention services, including services for members under 21, through:
    12.1. Sharing provider resources for wellness and prevention and clinical practice guidelines for preventive services.

12.1.1. Listings for Alliance wellness programs and wellness and prevention education handouts, care books and links are accessible on the Provider and Live Healthy pages of the Alliance website, www.alamedaalliance.org.

12.1.2. Resources are also shared in periodic provider webinars and at minimum yearly in the Provider Quarterly Packets.

12.1.3. Updates to the United State Preventive Services Task Force A and B recommendations and Bright Futures guidelines are updated as available up to quarterly through the Provider Quarterly Packets and on the Alliance website.

12.2. Monitoring provision of services through Population Health Management key performance indicators (KPIs) and program participation reports.

12.2.1. The Alliance monitors all DHCS required Population Health Management KPIs monthly.

12.2.2. The Alliance maintains reports of member participation in programs such as prenatal and parenting classes, breastfeeding support, referrals to smoking cessation and other wellness referrals and activities. See *HED-001 Health Education Program* for additional details.

12.3. Sharing education and HEDIS performance data with delegated entities.

12.3.1. The Alliance offers provider educational webinars on key HEDIS measures, including those relevant to members 21 and under. Webinars explain required services (such as dental care, developmental and cervical cancer screenings), best practices for successful performance on HEDIS measures, and Alliance wellness and prevention programs and resources.

12.3.2. The Alliance also shares monthly HEDIS measure gap in care reports with all delegated entities.

12.3.3. The Alliance also meets with delegates to share their HEDIS performance and offer quality improvement support to improve performance on HEDIS measures related to population health management and the quality bold goals, including measures relevant to members 21 and under. This information is communicated through articles in the Alliance provider newsletter.

DEFINITIONS / ACRONYMS

BPHM – Basic Population Health Management means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

CHW – Community Health Worker means an individual known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in All Plan Letter (APL) 22-016 or superseding APL.

CLAS – Culturally and Linguistically Appropriate Services

DHCS - California Department of Health Care Services

ECM – Enhanced Care Management means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a systematic coordination of

services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
EPSDT - Early and Periodic Screening, Diagnostic, and Treatment (also known as Medi-Cal for Teens and Kids) means the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC sections 1396a(a)(43) and 1396d(a)(4)(B) and (r), 42 CFR section 441.50 *et seq*., and as required by W&I sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or Behavioral Health conditions.
HEDIS – Healthcare Effectiveness Data and Information Set means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
IHA – Initial Health Appointment means an assessment that must be completed within 120 days of MCP enrollment for new Members and must include a history of the Member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and a diagnosis and plan for treatment of any diseases.
IVR – Interactive Voice Response
KPI – Key Performance Indicator
LTSS – Long-term Services and Supports means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS Programs, and includes carved-in and carved-out services.
MCP – Managed Care Plan
MOU – Memorandum of Understanding
NCQA – National Committee for Quality Assurance
PCP – Primary Care Provider means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.
PHM – Population Health Management means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.
WIC – Special Supplemental Nutrition Program for Women, Infants, and Children

AFFECTED DEPARTMENTS/PARTIES

Case Management
Member Services
Provider Services
Quality Improvement

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Services Program
CM-005 Disease Management Programs
CMP-019 Delegation Oversight
HED-002 Health Education Materials
PH-004 Community Health Worker (CHW) Services
QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-124 Initial Health Appointment
QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services
UM-002 Coordination of Care
UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens and Kids)
UM-025 Guidelines for Obstetrical Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy 9/19/2023

REFERENCES

DHCS CalAIM: Population Health Management (PHM) Policy Guide
DHCS 2024 MCP Contract

MONITORING

This Policy will be reviewed annually.

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	PH-002
Policy Name	Basic Population Health Management (BPHM)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Care and Group Care
Effective Date	9/19/2023
Subcommittee Name	~~Health Care~~ Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/18/2023~~11/17/~~2023~~TBD
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) offers Basic Population Health Management (BPHM) as a part of its Population Health Management (PHM) Program. BPHM services include access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs) under the ~~new~~ CHW benefit, wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children under Early and Periodic Screening, Diagnosis and Treatment (EPSDT, Medi-Cal for Kids & Teens).

All Alliance members receive BPHM, regardless of their level of need. BPHM services comply with the California Department of Health Care Services (DHCS) ~~All Plan Letter (APL) 22-024 Population Health Management Program Guide~~CalAIM: Population Health Management (PHM) Policy Guide, ~~the Amended DHCS 2023 Managed Care Plan (MCP) contract, and~~ the DHCS 2024 MCP Contract, or superseding APL or Contract, or Contract amendment. Where applicable, BPHM services meet NCQA PHM standards and align with the DHCS Comprehensive Quality Strategy.

PROCEDURE

1. The Alliance ensures its members receive BPHM services.

1.1. For members who are successfully engaged in primary care, the Alliance requires Primary Care Providers (PCPs) to be responsible for select care coordination and health education functions. For members who do not engage with a PCP, the Alliance assumes responsibility for provision of BPHM.
1.2. For members enrolled in Enhanced Care Management (ECM), the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of their care management.
1.3. For members who receive skilled nursing facility or other long term care services, BPHM services are provided by the facility physician or the member's assigned PCP. When additional care coordination is needed, Alliance Long Term Care team provides BPHM services.

2. The Alliance ensures that all members have access to and are utilizing primary care by:
2.1. Identifying members who are not using primary care via utilization reports and enrollment data, which are stratified by race and ethnicity, and developing strategies to address utilization patterns.
2.2. Ensuring members have appropriate, ongoing, and timely source of primary care to meet the member's needs.
2.3. Ensuring members are engaged with their assigned PCPs. For members who have been assigned a PCP but have not yet engaged with the PCP (e.g., assigned but not seen or lost to follow-up), the Alliance in coordination with PCP partners outreaches to the member.
2.3.1. Sharing outreach reports with delegates and PCPs on assigned members requiring outreach and education on the importance of outreach to engage members in care.
2.3.2. Sharing reports with PCPs on which members are due an Initial Health Appointment.
2.3.3. Monitoring HEDIS measures related to preventive health visits and screenings and addressing identified gaps.
2.4. As needed, conducting member outreach to ensure connection with their PCP and BPHM services.
2.5. Assisting members in making appointments, arranging transportation, and providing education on the importance of primary care or have not been seen within the last 12 months, particularly members less than 21 years of age.

3. The Alliance ensures child and youth members under 21 years of age receive EPSDT (Medi-Cal for Kids & Teens) services through their participation in BPHM, CCM, or ECM.
3.1. Monitor utilization of preventive health visits and developmental screenings, including relevant HEDIS measures.
3.2. Collaborate with community agencies and pediatric providers to address gaps in utilization through education, gap in care reports, and member incentives.
3.3. Contact members through live calls and IVR who have gaps in care with reminders, education and assistance in scheduling needed visits.
3.4. Track use of CHWs and BPHM care coordination efforts to ensure follow up and care coordination needs identified from screenings are delivered.
3.5. Establish Ensure members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities

3.6. Establish MOUs with First 5 programs and providers, WIC providers and every Local Education Agency (LEA) in Alameda County for school-based services to strengthen provision of EPSDT (Medi-Cal for Teens & Kids). ~~(starting in 2024.)~~

4. Alliance members may receive Care Coordination services and navigation and referrals across health and social services as needed. These services are described in Alliance Policy *UM-002 Coordination of Care*.

5. Alliance members are eligible for CHW services as described in Alliance policy *PH-~~XXX~~ 004 Community Health Worker (CHW) Services.*

6. The Alliance offers comprehensive wellness and prevention programs that meet NCQA PHM standards, including the provision of evidence-based self-management tools, and align with the DHCS Comprehensive Quality Strategy's Clinical Focus Areas and Bold Goals. The Alliance offers all members wellness and prevention programs, in collaboration with Local Government Agencies (LGAs) as appropriate. The Alliance:
   6.1. Uses the Population Needs Assessment (PNA) to identify specific, proactive wellness initiatives and programs that address member needs and reports this annually as part of the PHM Strategy as described in Alliance policy *PH-005 Population Assessment.*
   6.2. Addresses the NCQA required areas:
      6.2.1. Healthy weight maintenance
      6.2.2. Smoking and tobacco use cessation
      6.2.3. Encouraging physical activity
      6.2.4. Healthy eating
      6.2.5. Managing stress
      6.2.6. Avoiding at-risk drinking
      6.2.7. Identifying depressive symptoms
   6.3. Offers evidence-based disease management programs that comply with PHM NCQA standards including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, identify members for engagement, and seek to close care gaps for members participating in these programs. Disease Management Programs are described in the Alliance policy *CM-005 Disease Management Programs.*
   6.4. Implements evidence-based initiatives to improve access to preventative health visits, developmental screenings, and services for members less than 21 years of age.
   6.5. Implements evidence-based initiatives to improve pregnancy outcomes for women, including through 12 months postpartum.
   6.6. Implements evidence-based initiatives to ensure adults have access to preventive care, as described in the DHCS contract and in compliance with all applicable state and federal laws.
   6.7. Monitors the provision of wellness and preventive services by PCPs as part of our Site Review process. See Alliance policy *QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS).*
   6.8. Develops health education materials, in a manner that meets Members' health education and cultural and linguistic needs. Health Education materials development is described in Alliance policy *HED-002 Health Education Materials.*
   6.9. Implements evidence-based initiatives that are aimed at helping Members set and achieve wellness goals.

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6.10. Submits wellness and prevention programs to DHCS for review and approval in a form and method prescribed by DHCS.

~~7. The Alliance offers Chronic Disease Programs to members that comply with PHM NCQA standards and cover at a minimum Asthma, Diabetes, Cardiovascular Disease and Depression. Disease Management Programs are described in the Alliance policy *CM-005 Disease Management Programs*.~~

~~8.~~7. The Alliance continues to meet all requirements for pregnant individuals, including covering the provision of all medically necessary services for pregnant women, administering a comprehensive risk assessment tool comparable to the ACOG and CPSP standards, and providing appropriate follow-ups. Services for pregnant individuals are described in the Alliance Policy *UM-025 Guidelines for Obstetrical Services*.

8. The Alliance ensures members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities with whom the Alliance has or will have an executed MOU.

9. The Alliance provides the following services for members under 21:

   9.1. An Initial Health Appointment (IHA) within 120 calendar days of enrollment or within the AAP Bright Futures periodicity timeline for children ages 18 months and younger, whichever is sooner. (See *QI-124 IHA Policy*)
   9.2. Preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the AAP Bright Futures periodicity schedule, and immunizations specified by the Advisory Committee on Immunization Practices (ACIP) childhood immunization schedule. (See *QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services*).
   9.3. Ensures that all medically necessary services, including those that are not necessarily covered for adults, are provided as long as they could be Medicaid covered services. (See *QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services*).
   9.4. Coordinates health and social services for children between settings of care and across other MCPs and delivery systems. Specifically, MCPs must support children and their families in accessing medically necessary physical, behavioral, and dental health services, as well as social and educational services (See *UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens and Kids)*).

10. All BPHM services promote health equity and align with the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the U.S. Department of Health and Human Services that focus on the delivery of services in a culturally appropriate manner. The Alliance supports CLAS standards through its Cultural and Linguistic Services program (See *CLS-001 Cultural and Linguistic Services Program*).

11. The Alliance ensures non-duplication of BPHM services through documentation of participation in the Alliance Clinical Information System and reports that monitor member participation in BPHM services.

~~12. The Alliance provides the following resources to providers to assist in the provision of BPHM to all members.~~

~~12.1. The Alliance uses its Clinical Information System to electronically track and monitor referrals not requiring prior authorization, including referrals for care management services, and the outcomes of referrals.~~

~~12.2. The Alliance provides access to a current and continuously updated community resource directory to its network of providers.~~

~~12.3. The Alliance Provider Services department has a toll-free telephone number for network providers to obtain assistance in arranging referrals. Referrals may include mental health and substance use disorder treatment, developmental services, dementia, palliative care, dental, personal care services, and long-term services and supports (LTSS).~~

~~12.4. The Alliance communicates the availability of the telephone referral assistance by providing the toll-free number on the home page of the Alliance website and in provider communications, including the Alliance's Provider Manual.~~

~~13.~~12. The Alliance does not fully delegate wellness and prevention programs to subcontractors or downstream subcontractors. However, the Alliance works with our delegated entities to ensure provision of wellness and prevention services, including services for members under 21, through:

~~13.1.~~12.1. Sharing provider resources for wellness and prevention and clinical practice guidelines for preventive services.

~~13.1.1.~~12.1.1. Listings for Alliance wellness programs and wellness and prevention education handouts, care books and links are accessible on the Provider and Live Healthy pages of the Alliance website, www.alamedaalliance.org.

~~13.1.2.~~12.1.2. Resources are also shared in periodic provider webinars and at minimum yearly in the Provider Quarterly Packets.

~~13.1.3.~~12.1.3. Updates to the United State Preventive Services Task Force A and B recommendations and Bright Futures guidelines are updated as available up to quarterly through the Provider Quarterly Packets and on the Alliance website.

~~13.2.~~12.2. Monitoring provision of services through Population Health Management ~~population health management~~ key performance~~, HEDIS~~ indicators (KPIs)~~,~~ and program participation reports.

~~13.2.1.~~12.2.1. The Alliance monitors all DHCS required Population Health Management ~~HEDIS measures quarterly or as available~~KPIs monthly.

~~13.2.2.~~12.2.2. The Alliance maintains reports of member participation in programs such as prenatal and parenting classes, breastfeeding support~~, weight management~~, referrals to smoking cessation and other wellness referrals and activities. See *HED – 001 Health Education Program* for additional details.

~~13.3.~~12.3. Sharing education and HEDIS performance data with delegated entities.

~~13.3.1.~~12.3.1. The Alliance offers provider educational webinars on key HEDIS measures, including those relevant to members 21 and under. Webinars explain required services (such as dental care, developmental and cervical cancer screenings), best practices for successful performance on HEDIS measures, and Alliance wellness and prevention programs and resources.

~~13.3.2.~~12.3.2. The Alliance also shares monthly HEDIS measure gap in care reports with all delegated entities.

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12.3.3. The Alliance also meets with delegates to share their HEDIS performance and offer quality improvement support to improve performance on HEDIS measures related to population health management and the quality bold goals, including measures relevant to members 21 and under. ~~As well t~~This information is communicated through articles in the Alliance provider newsletter.

~~The Alliance includes in the annual Population Health Management Strategy how community-specific information and stakeholder input from the PNA is used to design and implement evidence-based wellness and prevention strategies.~~

~~13.3.3.~~

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DEFINITIONS / ACRONYMS

BPHM – Basic Population Health Management means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

CHW – Community Health Worker means an individual known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in All Plan Letter (APL) 22-016 or superseding APL.

CLAS – Culturally and Linguistically Appropriate Services

DHCS - California Department of Health Care Services

ECM – Enhanced Care Management means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

EPSDT - Early and Periodic Screening, Diagnostic, and Treatment (also known as Medi-Cal for Teens and Kids) means the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC sections 1396a(a)(43) and 1396d(a)(4)(B) and (r), 42 CFR section 441.50 *et seq*., and as required by W&I sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or Behavioral Health conditions.

HEDIS – Healthcare Effectiveness Data and Information Set means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

IHA – Initial Health Appointment means an assessment that must be completed within 120 days of MCP enrollment for new Members and must include a history of the Member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and a diagnosis and plan for treatment of any diseases.

IVR – Interactive Voice Response

KPI – Key Performance Indicator

LTSS – Long-term Services and Supports means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the

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setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS Programs, and includes carved-in and carved-out services.
MCP – Managed Care Plan
MOU – Memorandum of Understanding
NCQA – National Committee for Quality Assurance
PCP – Primary Care Provider means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.
PHM – Population Health Management means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.
WIC – Special Supplemental Nutrition Program for Women, Infants, and Children

AFFECTED DEPARTMENTS/PARTIES

Case Management
Member Services
Provider Services
Quality Improvement

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Services Program
CM-005 Disease Management Programs
CMP-019 Delegation Oversight
HED-002 Health Education Materials
PH-~~XXX~~ 004 Community Health Worker (CHW) Services
QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-124 Initial Health Appointment
QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services
UM-002 Coordination of Care
UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens and Kids)
UM-025 Guidelines for Obstetrical Services

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy 9/19/2023

REFERENCES

DHCS CalAIM: Population Health Management (PHM) Policy Guide~~All Plan Letter 22-024 Population Health Management Program Guide or superseding APL.~~

~~DHCS 2023 MCP Amended Contract~~

DHCS 2024 MCP Contract~~ or superseding contract or contract amendment.~~

MONITORING

This Policy will be reviewed annually.

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ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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POLICY AND PROCEDURE

Policy Number	PH-005
Policy Name	Population Assessment
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal, Group Care
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) assesses the needs of its member populations to identify population level health and social needs of the Alliance local communities and members and to identify health disparities.

The Alliance follows the Population Needs Assessment (PNA) requirements defined in the DHCS All Plan Letter APL-23-021, the DHCS CalAIM: Population Health Management (PHM) Policy Guide, or superseding APL, contract, or contract amendment. The Alliance meaningfully participates with Local Health Jurisdictions' Community Health Assessment (CHA) process to deepen the Alliance's understanding of our members and strengthen our relationship with the communities we serve. This allows us to holistically identify the needs and strengths within member communities so that together with our community partners, we can more effectively and sustainably improve the lives of members and with fewer siloed approaches to population health management.

In addition, the Alliance conducts an annual NCQA population assessment of Medi-Cal and Group Care members following the National Committee for Quality Assurance (NCQA)

Population Health Management accreditation requirements to assess the characteristics and needs, including social drivers of health, of its member population and relevant subpopulations.

Population analysis results are not used for underwriting or denial of coverage and benefits.

PROCEDURE

1. The Alliance meets the DHCS Population Needs Assessment (PNA) requirement by meaningfully participating in the Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) conducted by Local Health Jurisdictions (LHJs). For the Alliance, the LHJs are Alameda County and City of Berkeley.
   1.1. Between 2024 and 2027, MCPs will work with each LHJ on their CHA/CHIP according to their current timeline. Starting in 2028, all LHJs will be expected to be on the same three-year cycle with the LHJ CHA or data refresh to be completed in December 2028 and the CHIP or data refresh to be completed by June 30, 2029.
   1.2. Meaningful participation will align with DHCS definitions and includes but is not limited to data sharing, contribution of resources, and stakeholder engagement.
      1.2.1. The Alliance will collaborate with other MCPs in the same service area (i.e., Kaiser for Alameda County) to coordinate the types of staffing/funding to be provided, what data is to be shared, as well as communications with the LHJs.
      1.2.2. Between 2024 and 2027, the Alliance will begin sharing data with LHJs to support the CHA/CHIP process.
         1.2.2.1. In 2024, priority areas will be identified from the list provided in the DHCS CalAIM: PHM Policy Guide.
         1.2.2.2. Starting in Q2 of 2025 at the latest, data will be shared as agreed upon with the LHJ in accordance with all applicable laws and data sharing agreements. Data will be de-identified and suppressed according to LHJ or Alliance organizational guidelines for public use in collaborative analysis.
      1.2.3. The Alliance will contribute resources to support LHJs' CHAs/CHIPs in the form of funding and/or in-kind staffing starting on January 1, 2025.
         1.2.3.1. Starting in 2024, the Alliance will work with LHJs to determine the types of resources to contribute.
         1.2.3.2. Resource contribution decisions will be described in the MCP-LHJ Collaboration Worksheet and reported to DHCS via the annual PHM Strategy Deliverable submission.
   1.3. The Alliance and LHJs collaborate on at least one shared and meaningful goal that is accompanied by an objective that is SMART (specific, measurable, achievable, realistic, and time-bound). The objective:

1.3.1. Aligns with DHCS' Bold Goals (as described in DHCS' Comprehensive Quality Strategy).
1.3.2. Supports a relevant LHD project that is currently being implemented or about to be launched.
1.3.3. Has a start date prior to January 2024.
1.3.4. Is achievable in 1-2 years.

1.4. The Alliance will participate in stakeholder engagement starting in 2024.
1.4.1. Attend key CHA/CHIP meetings and/or serve on committees or subcommittees as requested by LHJs.
1.4.2. Engage the Alliance Community Advisory Committee.
1.4.2.1. Regularly report on involvement in and findings from CHAs/CHIPs.
1.4.2.2. Obtain input/advice on how to use findings to influence MCP strategies and workstreams related to Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.
1.4.2.3. Over time, work with LHJs to use the CAC as a resource for stakeholder participation in LHJ CHA/CHIPs.

2. The Alliance will complete a PHM Strategy Deliverable for each LHJ.
2.1. The Alliance will collaborate with other MCPs (i.e., Kaiser in Alameda County) to submit a single shared PHM Strategy Deliverable per LHJ.
2.2. For the 2024 PHM Strategy Deliverable, MCPs will need to report on:
2.2.1. How are they meaningfully participating on LHJs' CHAs/CHIPs
2.2.2. Bright spots
2.2.3. Challenges
2.2.4. How they are responding to community needs
2.2.5. Updates to the SMART goals developed in 2023, as required by the 2023 PHM Strategy Deliverable that are to commence in 2024.
2.2.6. In addition to the SMART goals, a description of how MCP involvement in LHJs' CHA/CHIP activities has impacted PHM Strategy. The Alliance will report annually, through the PHM Strategy, on how they are using community-specific information, gained in the more collaborative PNA efforts to design and implement evidence-based wellness and prevention strategies to meet the unique needs of their populations, as well as to drive toward the Bold Goals Initiative in DHCS' Comprehensive Quality Strategy.
2.2.7. Any other relevant PNA and PHM updates
2.3. to the Alliance will also provide updates to their NCQA PHM Strategy.

3. The PNA is shared publicly and with the Alliance Community Advisory Committee, providers, and staff.
3.1. When an LHJ publishes its CHA/CHIP, it will be published on the Alliance website with a brief paragraph on meaningful participation in the process.

3.2. PNA findings are shared with providers, fully delegated subcontractors, downstream fully delegated subcontractors, through presentations at the Quality Improvement Health Equity Committee meeting and provider communications distributed through quarterly provider visits and posted on the Alliance website.
3.3. PNA findings and action plans are shared via presentations at internal subcommittees and meetings with relevant Alliance departments for use in planning and guiding culturally and linguistically relevant programs and member communication.

4. Based on participation in the CHA/CHIP processes, the Alliance annually reviews and updates the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:
   4.1. Targeted health education materials for members
   4.2. Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services
   4.3. Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs
   4.4. Wellness and prevention programs

5. The Alliance develops an annual NCQA population assessment and uses the findings from both the population assessment and the PNA to develop the Alliance NCQA Population Health Management Strategy.
   5.1. The NCQA population assessment assesses the characteristics and needs including social drivers of health, of its member population, NCQA-required subpopulations, and special populations such as members eligible for Enhanced Care Management.
   5.2. The NCQA population assessment evaluates characteristics such as:
      5.2.1. Member demographics such as age, gender, racial and ethnic characteristics
      5.2.2. Cultural data such as primary language
      5.2.3. Health status, behaviors, and utilization trends
      5.2.4. Health disparities
      5.2.5. Social determinants (drivers) of health (SDOH)
      5.2.6. Member experience
      5.2.7. Gaps in services
   5.3. The Alliance uses reliable data sources to identify member health needs and health disparities. Data sources may include Alliance data, including data from subcontractors and downstream subcontractors such as:
      5.3.1. Member demographic data
      5.3.2. The most recently available member CAHPS survey results
      5.3.3. The most recently available DHCS Alliance-specific health disparities data
      5.3.4. HEDIS results
      5.3.5. Medical and behavioral claims or encounters

5.3.6. Pharmacy claims
5.3.7. Laboratory results when available
5.3.8. Alliance program enrollment and participation data (such as Enhanced Care Management)
5.3.9. Risk data
5.3.10. Advanced data sources as available
5.3.11. Needs assessments conducted by other entities and community-based organizations within Alameda County

DEFINITIONS/ACRONYMS

CAC – Community Advisory Committee
CAHPS – Consumer Assessment of Healthcare Providers and Systems is a survey asking health plan consumers about their health care experience. The tool is a product of the Agency for Healthcare Research and Quality.
CHA – Community Health Assessment, also known as a Community Health Needs Assessment (CHNA) in some circumstances, is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. Public health departments (state, local, territorial, Tribal) develop CHAs to meet voluntary Public Health Board Accreditation Board (PHAB) standards and State Future of Public Health funding requirements, and non-profit hospitals develop these CHNAs to meet federal and state requirements to obtain and maintain their tax-exempt status. A variety of tools and processes may be used to conduct these population-level assessments. The essential feature, as defined by the PHAB, is that the assessment is developed through a participatory, collaborative process with various key sectors of the community.
CHIP – Community Health Improvement Plan (CHIP; also known as Implementation Strategy, triennial public health plan, or Implementation Plan, or Community Benefits Plan) is the output of these population-level assessments (CHA or CHNA) CHA. The Community Health Improvement Plan is typically produced by public health departments (local, territorial, state or Tribal) for PHAB accreditation, State Local Assistance Spending Plan funding allocation, and non-profit hospitals to meet federal and state requirements.
DHCS – Department of Health Care Services
ECM – Enhanced Care Management
HEDIS – Healthcare Effectiveness Data and Information Set is a tool used by health plans in the United States. It measures performance on critical areas of care and service.
LHJ – Local Health Jurisdiction
MCP – Managed Care Plan
NCQA – National Committee for Quality Assurance
PHM – Population Health Management is a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member

needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

PHM Strategy – Population Health Management Strategy means an annual deliverable that the Alliance must submit to DHCS requiring the Alliance to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

PNA – Population Needs Assessment means a multi-year process during which a Contractor will identify and respond to the needs of its Members and the communities it serves by meaningfully participating in the community health assessment (CHA) of Local Health Departments (LHDs) in the service area(s) where Contractor operates. The findings of the PNA/CHA collaboration will inform the Contractor's annual PHM Strategy.

SDOH – Social Drivers of Health (also known as Social Determinants of Health) are the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functions and quality-of-life outcomes and risk factors.

Subpopulations – A group of individuals within the membership that share common characteristics.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Community Stakeholders
Provider Network

RELATED POLICIES AND PROCEDURES

HED-001 Health Education Program
CLS-001 Cultural and Linguistics Program Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

11/21/2006, 1/1/2008, 12/2009, 2/26/2010, 12/23/2013, 1/22/2014, 5/20/2015, 6/16/2016, 5/25/2017, 5/3/2018, 3/21/19, 3/19/2020, 3/18/2021, 11/18/21, 3/22/2022, 3/21/2023, TBD

REFERENCES

DHCS All Plan Letter 23-021 Population Needs Assessment an d Population Health Management Strategy

DHCS CalAIM: Population Health Management (PHM) Policy Guide

DHCS 2024 Contract

42 CFR sections 438.206(c)(2), 438.330(b)(4), and 438.242(b)(2)

22 CCR sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), 53904(a)(3), and 53910.5(a)(2),

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MONITORING

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

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	~~HED-003~~PH-005
Policy Name	Population ~~Needs~~ Assessment
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	Medi-Cal, Group Care
Effective Date	11/21/2006
Subcommittee Name	~~Health Care Quality~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/17/2023~~TBD
Compliance Committee Approval Date	~~3/21/2023~~TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) ~~annually~~ assesses the needs of its member populations to identify population level health and social needs of the Alliance local communities and members and to identify health disparities.

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The Alliance follows the Population Needs Assessment (PNA) requirements defined in the DHCS All Plan Letter APL-23-021, ~~and~~ the DHCS CalAIM: Population Health Management (PHM) Policy Guide, or superseding APL, contract, or contract amendment. The Alliance meaningfully participates with Local Health Jurisdictions' Community Health Assessment (CHA) process to deepen the Alliance's understanding of our members and strengthen our relationship with the communities we serve. This allows us to holistically identify the needs and strengths within member communities so that together with our community partners, we can more effectively and sustainably improve the lives of members and with fewer siloed approaches to population health management.

In addition, ~~T~~the Alliance conducts an annual NCQA population assessment of Medi-Cal and Group Care members following the National Committee for Quality Assurance (NCQA)

Population Health Management accreditation requirements to assess the characteristics and needs, including social drivers of health, of its member population and relevant subpopulations. ~~to identify member health needs and disparities;~~ ~~The~~ PNA ~~also serves to evaluate current plan activities, including health education, Cultural & Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and services, and available resources to address identified concerns; determine relevant subpopulation, and implement targeted, person-centered interventions for Alliance quality improvement, basic population health management and case management programs and services, including addressing identified health inequities.~~

~~In addition, the Alliance follows the Population Needs Assessment requirements defined in the DHCS All Plan Letter APL 23-021. The Alliance meaningfully participates with our local health departments within their Community Health Assessment (CHA) process to deepen the Alliance's understanding of our members and strengthen our relationship with the communities we serve. This allows us to holistically identify the needs and strengths within member communities so that together with our community partners, we can more effectively and sustainably improve the lives of members and with fewer siloed approaches to population health management.~~

Population analysis results are not used for underwriting or denial of coverage and benefits. ~~The Alliance Population Needs Assessment follows the requirements defined in the DHCS All Plan Letter APL 19-011. In addition, the Alliance follows the National Committee for Quality Assurance (NCQA) Population Health Management accreditation requirements to assess the characteristics and needs, including social drivers of health, of its member population and relevant subpopulations.~~

PROCEDURE

1. The Alliance meets the DHCS Population Needs Assessment (PNA) requirement by meaningfully participating in the Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) conducted by Local Health Jurisdictions (LHJs). For the Alliance, the LHJs are Alameda County and City of Berkeley.
    - 1.1. Between 2024 and 2027, MCPs will work with each LHJ on their CHA/CHIP according to their current timeline. Starting in 2028, all LHJs will be expected to be on the same three-year cycle with the LHJ CHA or data refresh to be completed in December 2028 and the CHIP or data refresh to be completed by June 30, 2029.
    - 1.2. Meaningful participation will align with DHCS definitions and includes but is not limited to data sharing, contribution of resources, and stakeholder engagement.
        - 1.2.1. The Alliance will collaborate with other MCPs in the same service area (i.e., Kaiser for Alameda County) to coordinate the types of staffing/funding to be provided, what data is to be shared, as well as communications with the LHJs.

1.2.2. Between 2024 and 2027, the Alliance will begin sharing data with LHJs to support the CHA/CHIP process.

1.2.2.1. In 2024, priority areas will be identified from the list provided in the DHCS CalAIM: PHM Policy Guide.

1.2.2.2. Starting in Q2 of 2025 at the latest, data will be shared as agreed upon with the LHJ in accordance with all applicable laws and data sharing agreements. Data will be de-identified and suppressed according to LHJ or Alliance organizational guidelines for public use in collaborative analysis.

1.2.3. The Alliance will contribute resources to support LHJs' CHAs/CHIPs in the form of funding and/or in-kind staffing starting on January 1, 2025.

1.2.3.1. Starting in 2024, the Alliance will work with LHJs to determine the types of resources to contribute.

1.2.3.2. Resource contribution decisions will be described in the MCP-LHJ Collaboration Worksheet and reported to DHCS via the annual PHM Strategy Deliverable submission.

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1.3. The Alliance and LHJs collaborate on at least one shared and meaningful goal that is accompanied by an objective that is SMART (specific, measurable, achievable, realistic, and time-bound). The objective:

1.3.1. Aligns with DHCS' Bold Goals (as described in DHCS' Comprehensive Quality Strategy).

1.3.2. Supports a relevant LHD project that is currently being implemented or about to be launched.

1.3.3. Has a start date prior to January 2024.

1.3.4. Is achievable in 1-2 years.

1.4. The Alliance will participate in stakeholder engagement starting in 2024.

1.4.1. Attend key CHA/CHIP meetings and/or serve on committees or subcommittees as requested by LHJs.

1.4.2. Engage the Alliance Community Advisory Committee.

1.4.2.1. Regularly report on involvement in and findings from CHAs/CHIPs.

1.4.2.2. Obtain input/advice on how to use findings to influence MCP strategies and workstreams related to Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.

1.4.2.3. Over time, work with LHJs to use the CAC as a resource for stakeholder participation in LHJ CHA/CHIPs.

2. The Alliance will complete a PHM Strategy Deliverable for each LHJ.

2.1. The Alliance will collaborate with other MCPs (i.e., Kaiser in Alameda County) to submit a single shared PHM Strategy Deliverable per LHJ.

2.2. For the 2024 PHM Strategy Deliverable, MCPs will need to report on:

2.2.1. How are they meaningfully participating on LHJs' CHAs/CHIPs

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2.2.2. Bright spots
2.2.3. Challenges
2.2.4. How they are responding to community needs
2.2.5. Updates to the SMART goals developed in 2023, as required by the 2023 PHM Strategy Deliverable that are to commence in 2024.
2.2.6. In addition to the SMART goals, a description of how MCP involvement in LHJs' CHA/CHIP activities has impacted PHM Strategy. ~~MCPs will be required to~~The Alliance will report annually, through the~~ir~~ PHM Strategy, on how they are using community-specific information, gained in the more collaborative PNA efforts to design and implement evidence-based wellness and prevention strategies to meet the unique needs of their populations, as well as to drive toward the Bold Goals Initiative in DHCS' Comprehensive Quality Strategy.
2.2.7. Any other relevant PNA and PHM updates

2.3. ~~MCPs will also need to~~to the Alliance will also provide updates to their NCQA PHM Strategy.

3. The PNA is shared publicly and with the Alliance Community Advisory Committee, providers, and staff.
3.1. When an LHJ publishes its CHA/CHIP, it will be published on the Alliance website with a brief paragraph on meaningful participation in the process.
3.2. PNA findings are shared with providers, fully delegated subcontractors, downstream fully delegated subcontractors, through presentations at the Quality Improvement Health Equity Committee meeting and provider communications distributed through quarterly provider visits and posted on the Alliance website.
3.3. PNA findings and action plans are shared via presentations at internal subcommittees and meetings with relevant Alliance departments for use in planning and guiding culturally and linguistically relevant programs and member communication.

4. Based on participation in the CHA/CHIP processes, the Alliance annually reviews and updates the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:
~~1.1.~~4.1. Targeted health education materials for members
4.2. Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services
~~1.2.~~4.3. Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs
4.4. Wellness and prevention programs

5. The Alliance develops an annual ~~Population Needs Assessment~~NCQA population assessment and uses the ~~results~~findings from both the population assessment and the PNA -to develop

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the Alliance ~~annual~~ NCQA Population Health Management Strategy. ~~(See *PH-001 Population Health Management Strategy*).~~

~~1.3.~~5.1. The ~~The~~ NCQA population assessment~~Alliance PNA~~ ~~PHA~~ assesses the ~~unique~~ characteristics and needs including social drivers of health, of its member population~~, including the~~, ~~and~~ NCQA-required subpopulations, and special populations such as members eligible for Enhanced Care Management.

~~2.~~5.2. The ~~Alliance PNA~~NCQA population assessment ~~examines~~evaluates characteristics such as:

5.2.1. Member demographics such as age, gender, racial and ethnic characteristics

5.2.2. Cultural data such as primary language

5.2.3. Health status, behaviors, and utilization trends

5.2.4. Health disparities

~~2.1.~~ Social determinants (drivers) of health (SDOH)

5.2.5.

~~Any gaps in services and resources, even if not Alliance covered services.~~

~~2.2. Member demographics such as age, gender, racial and ethnic characteristics~~

~~2.3. Cultural data such as primary language~~

~~2.4. Health status and behaviors~~

~~2.5. Social drivers of health (SDOH)~~

~~2.6. Member health education and C&L needs, programs and resources~~

~~2.7.~~5.2.6. Member experience

~~2.8. Health disparities~~

~~2.9.~~ Gaps in services~~, and~~

~~2.9.1. The previous year's action plan objectives and activities.~~

5.2.7.

~~2.10.~~

~~3.~~ The Alliance uses reliable data sources to identify member health needs and health disparities. Data sources may include Alliance data, including data from subcontractors and downstream subcontractors such as:~~The Alliance uses reliable data sources to identify member health needs and health disparities. Data sources may include: Alliance data, including data from subcontractors and downstream subcontractors such as:~~

~~3.1.~~5.3. ~~Member demographic data~~

5.3.1. Member demographic data

~~3.2.~~5.3.2. The most recently available member CAHPS survey results

~~3.3.~~5.3.3. The most recently available DHCS Alliance-specific health disparities data

~~3.4.~~5.3.4. HEDIS results

~~3.5.~~5.3.5. Medical and behavioral claims or encounters

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~~3.6.~~5.3.6. Pharmacy claims
~~3.7.~~5.3.7. Laboratory results when available
~~3.8.~~5.3.8. Alliance program enrollment and participation data (such as Enhanced Care Management)
~~3.9.~~5.3.9. Risk data
~~3.9.1.~~5.3.10. Advanced data sources as available
5.3.11. Needs assessments conducted by other entities and community-based organizations within Alameda County

~~The Alliance engages representatives from Alameda County entities in order to assess member needs. Entities include:~~
- ~~Local health departments~~
- ~~Local education agencies~~
- ~~Local government agencies~~
- ~~Safety net providers~~

~~3.10. Community based organizations~~
- ~~Alameda County Behavioral Health~~
- ~~Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC-ODS) plans~~
- ~~Community mental health programs,~~
- ~~Primary care providers~~
- ~~Social service providers~~
- ~~Regional Centers (RC)~~
- ~~California Department of Corrections and Rehabilitation~~
- ~~County jails and juvenile facilities~~
- ~~Child welfare agencies~~

~~3.11. Stakeholders from special needs groups, including Seniors and Persons with Disabilities (SPD), Children with Special Health Care Needs (CSHCN), Members with Limited English Proficiency (LEP), and other Member subgroups from diverse cultural and ethnic backgrounds.~~~~County~~

~~4. The Alliance~~ annual ~~PNA findings generate recommendations for the development, review, and update of the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:~~
- ~~4.1. Programs that support specific conditions or at-risk population groups.~~
- ~~4.2. Cultural and linguistic and qu~~Quality improvement activities ~~strategies~~ to improve the ~~quality of care and service to members,~~address ~~population-level health and social needs. including linguistically diverse membership.~~
- ~~Basic population health management activities, including wellness and prevention programs, targeted health education materials, and programs that promote wellness and self-management of chronic conditions for members at low and risking risk.~~

4.3. Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to non-specialty mental health services.

4.4. Complex case management program including processes, activities, resources, and community resources.

4.5. The action plan will outline health education, C&L, and QI program targeted strategies, including at least one strategy to reduce health disparities.

5. The Alliance ensures stakeholder engagement withparticipation in the PNA. Results thatthat the PNA Report is are shared with the Alliance Member Advisory Committee (MAC, the Alliance's Community Advisory Committee), providers, and staff will include overall needs of members, as well as specific needs of CSHCN, SPDs, members with LEP, members enrolled in ECM, and other subgroups from diverse cultural and ethnic backgrounds.

The Alliance Member Advisory Committee provides input advice and recommendations on the PNA.

5.1. MAC members are invited to participate in the into the planning process, offer comments on the PNA findings, and suggests improvement opportunities, and are updated on PNA objectives at the MAC meetings.

5.2. The Alliance incorporates data and results of our providers, fully delegated subcontractors, downstream fully delegated subcontractors into the development of the PNA. As well the Alliance regularly updates providers, fully delegated subcontractors, downstream fully delegated subcontractors on PNA activities, findings and recommendations findings and action plan are shared with providers, fully delegated subcontractors, downstream fully delegated subcontractors, practitioners, and allied health care personnel via through presentations on PNA findings at the Health Care QualityQuality Improvement Health Equity Committee meeting and provider communications distributed through quarterly provider visits and posted on the Alliance website.

PNA findings and action plans are shared via presentations at internal subcommittees and meetings with relevant Alliance departments for use in planning and guiding culturally and linguistically relevant programs and member communication.

5.3. The Alliance produces its PNA in writing and makes it available to the public, and posts it on our website.

6. The Alliance will comply with DHCS required timeframes and formatting requirements for completion of the PNA.

6.1. The PNA shows a clear link between data sources, key data findings and identified opportunities for improvement, and action plan objectives

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6.2. The full PNA report is submitted for approval to MMCHealthEducationMailbox@dhcs.ca.gov with a cc: to the MCP's assigned Managed Care Operations Division Contract Manager.

- The Alliance collaborates with local health departments (LHD), Alameda County Health Care Services Agency, and City of Berkeley Health, Housing and Community Services, in their Community Health Assessment (CHA) process through meaningful participation.
  - Meaningful participation will align with DHCS definitions and may include, but is not limited to data sharing, CHA committee participation or leadership, or financial support.
  - Co-development of at least one shared and meaningful goal that is accompanied by an objective that is SMART (specific, measurable, achievable, realistic, and time-bound). The objective will:
    - Align with DHCS' Bold Goals (as described in DHCS' Comprehensive Quality Strategy).
    - Support a relevant LHD project that is currently being implemented or about to be launched.
    - Have a start date prior to January 2024.
    - Be achievable in 1 – 2 years.
  - The results of these collaborative PNA efforts are used to design and implement evidence-based wellness and prevention strategies to meet the needs of the Alliance populations and align with the Bold Goals.
  - In the annual Population Health Management (PHM) Strategy, the Alliance reports how the community-specific information in the PNA informs wellness and prevention activities and supports the DHCS Bold Goals.

7. The Alliance will comply with the NCQA Population Health Management requirements.
   7.1. The population health assessment will be conducted annually, or more frequently as needed due to changing demographics.

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DEFINITIONS/ACRONYMS

CAC – Community Advisory Committee

CAHPS – Consumer Assessment of Healthcare Providers and Systems is a survey asking health plan consumers about their health care experience. The tool is a product of the Agency for Healthcare Research and Quality.

CHA – Community Health Assessment, also known as a Community Health Needs Assessment (CHNA) in some circumstances, is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. Public health departments (state, local, territorial, Tribal) develop CHAs to meet voluntary Public Health Board Accreditation Board (PHAB) standards and State Future of Public Health funding requirements, and non-profit hospitals develop these CHNAs to meet federal and state requirements to obtain and maintain their tax-exempt status. A variety of tools and processes

may be used to conduct these population-level assessments. The essential feature, as defined by the PHAB, is that the assessment is developed through a participatory, collaborative process with various key sectors of the community.

CHIP – Community Health Improvement Plan (CHIP; also known as Implementation Strategy, triennial public health plan, or Implementation Plan, or Community Benefits Plan) is the output of these population-level assessments (CHA or CHNA) CHA. The Community Health Improvement Plan is typically produced by public health departments (local, territorial, state or Tribal) for PHAB accreditation, State Local Assistance Spending Plan funding allocation, and non-profit hospitals to meet federal and state requirements.

~~**CSHCN** – Children with Special Health Care Needs~~

~~**C&L** – Cultural and Linguistic services~~

DHCS – Department of Health Care Services

ECM – Enhanced Care Management

HEDIS – Healthcare Effectiveness Data and Information Set is a tool used by health plans in the United States. It measures performance on critical areas of care and service.

~~**LEP** – Limited English Proficiency~~

LHJ – Local Health Jurisdiction

~~**MAC** – Member Advisory Committee (serves as the Alliance's Community Advisory Committee)~~

MCP – Managed Care Plan

NCQA – National Committee for Quality Assurance

PHM – Population Health Management is a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

PHM Strategy – Population Health Management Strategy means an annual deliverable that the Alliance must submit to DHCS requiring the Alliance to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

PNA – Population Needs Assessment means a multi-year process during which a Contractor will identify and respond to the needs of its Members and the communities it serves by meaningfully participating in the community health assessment (CHA) of Local Health Departments (LHDs) in the service area(s) where Contractor operates. The findings of the PNA/CHA collaboration will inform the Contractor's annual PHM Strategy.

~~**QI** – Quality Improvement~~

SDOH – Social Drivers of Health (also known as Social Determinants of Health) are the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functions and quality-of-life outcomes and risk factors.

~~**SPD** – Seniors and Persons with Disabilities~~

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~~**SPMI** – Serious and Persistent Mental Illness, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment and interferes with or limits one or more major life activities.~~

Subpopulations – A group of individuals within the membership that share common characteristics.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Community Stakeholders
Provider Network

RELATED POLICIES AND PROCEDURES

HED-001 Health Education Program
CLS-001 Cultural and Linguistics Program Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

~~Sample PNA Reporting Template~~

REVISION HISTORY

11/21/2006, 1/1/2008, 12/2009, 2/26/2010, 12/23/2013, 1/22/2014, 5/20/2015, 6/16/2016, 5/25/2017, 5/3/2018, 3/21/19, 3/19/2020, 3/18/2021, 11/18/21, 3/22/2022, 3/21/2023, TBD

REFERENCES

DHCS All Plan Letter ~~19-011 Health Education and Cultural and Linguistic Group Needs Assessment~~23-02~~2~~1 Population ~~Health Management and Population Needs Assessment~~Needs Assessment an d Population Health Management Strategy

DHCS CalAIM: Population Health Management (PHM) Policy Guide

DHCS 2024 Contract ~~, Exhibit A, Attachment 9, Cultural and Linguistic Program~~

42 CFR sections 438.206(c)(2), 438.330(b)(4), and 438.242(b)(2)

22 CCR sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), 53904(a)(3), and 53910.5(a)(2),

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MONITORING

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

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POLICY AND PROCEDURE

Policy Number	QI-124
Policy Name	Initial Health Appointment (IHA)
Department Name	Healthcare Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality Improvement
Line(s) of Business	Medi-Cal
Effective Date	12/17/2015
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

An Initial Health Appointment (IHA) is a comprehensive assessment that is completed during a patient's initial encounter(s) with his/her Primary Care Physician (PCP). The IHA is part of Alameda Alliance for Health's Population Needs Assessment to ensure that we determine and address the health needs of our members by providing access to preventive health care, timely screenings, and referrals. The Alliance is required by the California Department of Health Care Services (DHCS), the Centers for Medicare and Medicaid to ensure that new members receive an Initial Health Appointment (IHA) within 120 days of becoming an Alliance member.

PROCEDURE

IHA Assessment Components

The IHA consists of a history, physical and mental health exam, an identification of risks per PCP assessment, appropriate age dependent preventive screens or services and health education, and the diagnosis and plan for treatment of any disease. If the medical records contains this information with the previous 12 months, the member does not require an IHA.

1. Comprehensive Physical and Mental Health Exam – the exam is conducted to assess and diagnose both acute and chronic conditions.

a. History of Present Illness
b. Past Medical History
    i. Prior major illness and injuries
    ii. Current medications
    iii. Allergies
c. Social History
    i. Marital status and living arrangement
    ii. Current employment
    iii. Occupational history
    iv. Use of alcohol, drugs and tobacco
    v. Level of education
    vi. Sexual History
    vii. Any other relevant social factors

2. Identification of Risks – the Alliance adheres to the provision of all Medically Necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA. The Alliance ensures that these services are initiated as soon as possible but no later than 60 days.
    a. This may include items including family history contributing to member disease, lifestyle that contributes to disease, and / or primary medical disease (i.e. DM) that may contribute to worsening secondary disease (CKD / ESRD).
3. Preventive Services
    a. Asymptomatic Health Adults
        i. The Alliance adheres to the Grade "A" and "B" recommendations of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF). Alliance providers must document the status of current recommended services.
    b. Members Under 21 Years of Age
        i. The Alliance provides preventive services for all members less than 21 years of age as specified by the most recent American Academy of Pediatrics (AAP)/Bright Futures age-specific guidelines and periodicity schedule. Alliance providers must document the status of current age-specific assessments and recommended services.
    c. 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).
4. Health Education
5. Diagnoses and Plan of Care
    a. Alliance providers create a plan of care that includes all follow-up activities.

Administration of the IHA

The following practitioners may administer the IHA:

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1. Any PCP, as long as the PCP of record ensures that the documentation of the IHA is maintained in the member's primary medical record, completed in an accurate and comprehensive manner, and available during subsequent preventive health visits.

2. Alliance perinatal care providers may administer the IHA through the initial prenatal visit(s). They must document that the prenatal visit(s) met the IHA content and timeline requirements.

3. PCPs who may administer the IHA include California licensed physicians qualified to serve as general practitioners. Or specific Alliance physicians who are board certified or board eligible in the following medical specialties: Internal Medicine, Pediatrics, Obstetrics/Gynecology, or Family Practice.

4. Non-Physician Mid-Level Practitioners such as nurse practitioners, certified nurse midwives, physician assistants, clinical nurse specialists and PCPs in training.

5. The IHA may be performed in the following settings:
    a. Medical settings should be designated as general practice, pediatrics, obstetrics, gynecology, and internal medicine in alignment with the definition of PCs.

Timelines for Provision of the IHA

An IHA must be scheduled and completed by PCPs as follows:

1. IHA will be conducted with all members within 120 days of initial enrollment unless excepted as noted in "Excluded Members" below; or documented within the past 12 months prior to member's enrollment, and the PCP determines that the Member's medical record contains complete and current information consistent with the Alliance assessment.

2. For members under the age of 18 months, the IHA will be completed within 120 calendar days following the date of enrollment or within the periodicity timeline established by the American Academy of Pediatrics (AAP) for ages two and younger, whichever is less.

3. If a member requests, or the Alliance initiates a change in PCP assignment within the first 120 days of enrollment, and the IHA has not yet been completed, the IHA must be completed by the newly assigned PCP within the established timeline for new members.

4. The Alliance ensures that subcontracted provider organizations selected or assigned to a member receive timely notification of a member's effective date of enrollment to allow scheduling and completion of the IHA within the required timeframe.

5. The effective date of enrollment is defined as:
    a. The first of the month following notification from DHCS that the member is eligible to be an Alliance member, the member is not on "hold" status, and capitation will be paid.

b. For infants born to Alliance members, the effective date of enrollment is the date of birth. The Alliance covers the infant under the mother's enrollment from date of birth through the last day of the following month.
c. In cases of retroactive enrollment, the effective date will be the date the Alliance receives notification of the member's enrollment.

Codes that qualify for IHA:

Provider	CPT Code	Description
PCP	99201 – 99205, 99461, G0438, Z1016	Office or other outpatient visit for the evaluation and management of new patient
PCP	99211-99215, G0439, Z00.01, Z00.110, Z00.111, Z00.8, Z02.1, Z02.3, Z02.5	Office or other outpatient visit for the evaluation and management of established patient with PCP but new to the Alliance
PCP	99381-99387	Comprehensive Preventive Visit and management of a new patient
PCP	99391-99397	Comprehensive Preventive Visit and management of an established patient with PCP but new to the Alliance
OB/Gyn	59400, 59425, 59426, 59430, 59510, 59610, 59618, Z1000, Z1008, Z1020, Z1032, Z1034, Z1036, Z1038	Under Vaginal Delivery, Antepartum and Postpartum Care Procedures, Under Cesarean Delivery Procedures, Under Delivery Procedures After Previous Cesarean Delivery, Under Delivery Procedures After Previous Cesarean Delivery
Behavioral Health	96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)

Excluded Members:

Individual members may be excluded from the IHA requirement under the following circumstances, and only if documented in the medical record:

1. All elements of the IHA were completed within the 12 months prior to enrollment, and the member's primary care services provider determines the requirements for documentation of the IHA are met.
2. New members who choose their current PCP as their new plan PCP provider, an IHA must still be completed within 120 days enrollment.
3. New members who are not continuously enrolled with the Alliance for 120 days.

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4. Members, including emancipated minors, or a member's parent(s) or guardian(s), who refuses an IHA. In this case, a statement signed by the member must be documented in the member's medical record. If the member or the party legally responsible for the member refuses to sign a refusal statement, the verbal refusal of services will be noted in the medical record.
5. The member missed a scheduled PCP appointment and **TWO** additional documented attempts to reschedule have been unsuccessful. If these efforts prove to be unsuccessful, the documentation must include at least the following:
    a. One attempt to contact member by phone.
    b. One attempt to contact member by letter or postcard sent to the address in the Alliance's records
    c. The Alliance's good faith effort to update the member's contact information.
    d. Attempts to perform the IHA at subsequent member office visit(s).

Provider Communication

1. The Alliance incorporates IHA requirements in the new provider orientation, the Provider Manual, fax blasts, regular primary care visits (by provider representative), during Facility Site Reviews, and provider meetings/webinars.

Informing Members

1. The Alliance informs members about the IHA through the Evidence of Coverage; welcome letters, videos on our website, and member outreach.
2. Member information on the IHA includes:
    a. The availability of the IHA for all members
    b. Instructions on how to arrange for an IHA appointment within the appropriate timelines.
    c. The importance of keeping the IHA and other appointments.
    d. Member rights, including providing the member the results of the IHA.'
3. The Alliance makes reasonable attempts (a minimum of two outreach recommended) to contact members to schedule IHA.

Compliance with IHA:

1. Monthly, the Alliance pulls claims and encounters with specific visit codes listed above, for primary care providers to identify the percentage of their newly and reassigned assigned members who had a visit within 120 days of being assigned.

2. An Alliance Facility Site Review (FSR) Nurse routinely reviews and validates medical records for compliance with IHA standards as part of the triennial FSR process. The FSR Nurse ensures that 30% of medical records selected for review are for members eligible for an IHA (e.g., those with an effective date within the review period who have been a member for 120 days or longer). Records are determined to be compliant if all of the following criteria are met:
    a. The member had a PCP visit within the first 120 days of enrollment or documented within the 12 months prior to Alliance enrollment, and

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b. During the encounter and subsequent encounters, the IHA elements listed above were completed.
c. If IHA was not completed, FSR Nurse will review documentation of the attempts made to contact members.
d. Failure to complete IHA or provide evidence of outreach attempts can result in a Corrective Action Plan (CAP).

3. Quarterly results and reports are reviewed. Opportunities for improvement are discussed and aggregated results are annually shared with the Quality Improvement Health Equity Committee (QIHEC).
4. The Alliance shall cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. The Alliance ensures that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.
5. In the absence of risk factors and the need for immediate follow-up, core preventive services for the IHA for adults should be offered in the frequency required by the USPSTF Guide to Clinical Preventive Services
6. In the absence of risk factors and the need for immediate follow-up, core preventive services for the IHA for the pediatric population should be offered in the frequency required by the American Academy of Pediatrics (AAP)/Bright Futures age-specific guidelines
7. For newly pregnant women, Alliance will refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c).
8. Alliance will report to the immunization registry(ies) established in the service area as part of the Statewide Immunization Information System, following the Member's IHA and all other health care visits which result in an immunization.

Monitoring:

The Quality Improvement (QI) Department will conduct a chart review audit of members who have been with the plan for 120 days and have had at least one provider visit. This will be done at a minimum annually. The purpose of these reviews will be to determine if all components of the IHA have been completed, and whether the completion followed the policy guidelines. Providers who fail to complete all elements of the IHA are notified and offered education on meeting the IHA requirements. If there are noted trends by a provider in failure to meet all of the IHA requirements may result in the issuance of a Corrective Action Plan (CAP).

Data Sharing

1. The Alliance shares IHA data with providers, subcontractors, and other sub-plan entities to facilitate care coordination for their members.

DEFINITIONS / ACRONYMS

American Academy of Pediatrics (AAP)
Facility Site Review (FSR)

Initial Health Appointment (IHA)
Primary Care Physician (PCP)
U.S. Preventive Services Task Force (USPSTF)

AFFECTED DEPARTMENTS/PARTIES

Medical Services, Quality Improvement

RELATED POLICIES AND PROCEDURES

APL 22-030

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

12/17/2015, 8/29/2016, 1/04/2017, 4/12/2018, 11/15/2018, 1/16/2020, 11/19/2020, 3/21/2023, 1/16/2024

REFERENCES

Title 42, Section 438.208
Alameda Alliance Provider Manual

MONITORING

This Policy will be reviewed annually to ensure compliance with regulatory and contractual requirements. On review of this P&P, codes will also be re-evaluated and validated.

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POLICY AND PROCEDURE

Policy Number	QI-124
Policy Name	Initial Health Appointment (IHA)
Department Name	Healthcare Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality Improvement
Line(s) of Business	Medi-Cal
Effective Date	12/17/2015
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	TBD~~3/21/2023~~

POLICY STATEMENT

An Initial Health Appointment (IHA) is a comprehensive assessment that is completed during a patient's initial encounter(s) with his/her Primary Care Physician (PCP). The IHA is part of Alameda Alliance for Health's Population Needs Assessment to ensure that we determine and address the health needs of our members by providing access to preventive health care, timely screenings, and referrals. The Alliance is required by the California Department of Health Care Services (DHCS), the Centers for Medicare and Medicaid to ensure that new members receive an Initial Health Appointment (IHA) within 120 days of becoming an Alliance member.

PROCEDURE

IHA Assessment Components

The IHA consists of a ~~comprehensive~~ history, ~~,~~ physical and ~~,~~ mental health exam, an identification of risks per PCP assessment, ~~an assessment of need for~~ appropriate age dependent preventive screens or services and health education, ~~a physical examination,~~ and the diagnosis and plan for treatment of any disease. If the medical records contains this information with the previous 12 months, the member does not require an IHA. ~~, unless the Member's Primary Care Provider (PCP) determines that the Member's medical Record~~

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~~contains complete information, updated within the previous 12 months. status and where age appropriate, developmental exam, diagnosis and plan of care, and preventive services.~~

1. Comprehensive Physical and Mental ~~Status~~ Health Exam – the exam is conducted to assess and diagnose both acute and chronic conditions.
    a. History of Present Illness
    b. Past Medical History
        i. Prior major illness and injuries
        ~~ii. Prior operations~~
        ~~iii. Prior hospitalizations~~
        ~~iv.~~ii. Current medications
        ~~v.~~iii. Allergies
        ~~vi. Age appropriate immunization status~~
        ~~vii. Age appropriate feeding and dietary status~~
    c. Social History
        i. Marital status and living arrangement
        ii. Current employment
        iii. Occupational history
        iv. Use of alcohol, drugs and tobacco
        v. Level of education
        vi. Sexual History
        vii. Any other relevant social factors
2. Identification of Risks – the Alliance adheres to the provision of all Medically Necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA. The Alliance ensures that these services are initiated as soon as possible but no later than 60 days.
    ~~2.~~a. This may include items including family history contributing to member disease, lifestyle that contributes to disease, and / or primary medical disease (i.e. DM) that may contribute to worsening secondary disease (CKD / ESRD).
3. Preventive Services
    a. Asymptomatic Health Adults
        i. The Alliance adheres to the Grade "A" and "B" recommendations ~~current edition~~ of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF)~~, in particular the Grade "A" and "B" recommendations.~~ Alliance providers must document the status of current recommended services.
    b. Members Under 21 Years of Age
        i. The Alliance provides preventive services for all members less than 21 years of age as specified by the most recent American Academy of Pediatrics (AAP)/Bright Futures age-specific guidelines and periodicity schedule. Alliance providers must document the status of current age-specific assessments and recommended services.

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c. 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).

4. Health Education
5. Diagnoses and Plan of Care
    a. Alliance providers create a plan of care that includes all follow-up activities.

Administration of the IHA

The following practitioners may administer the IHA:

1. Any PCP, as long as the PCP of record ensures that the documentation of the IHA is maintained in the member's primary medical record, completed in an accurate and comprehensive manner, and available during subsequent preventive health visits.

2. Alliance perinatal care providers may administer the IHA through the initial prenatal visit(s). They must document that the prenatal visit(s) met the IHA content and timeline requirements.

3. PCPs who may administer the IHA include California licensed physicians qualified to serve as general practitioners. Or specific Alliance physicians who are board certified or board eligible in the following medical specialties: Internal Medicine, Pediatrics, Obstetrics/Gynecology, or Family Practice.

4. Non-Physician Mid-Level Practitioners such as nurse practitioners, certified nurse midwives, physician assistants, clinical nurse specialists and PCPs in training.

5. The IHA may be performed in the following settings:
    ~~a. Ambulatory Care~~
    ~~b. Nursing Facility, using the facility assessment for information, and completed and reviewed by the member's assigned PCP.~~
    ~~c. Home Visits as long as all components are completed within the required timelines.~~
    ~~d.~~a. ~~Hospital: PCPs may complete the IHA within the hospital for hospitalized members. They can include hospital admission history and physical as well as a post-charge visit to complete the IHA.~~Medical settings should be designated as general practice, pediatrics, obstetrics, gynecology, and internal medicine in alignment with the definition of PCs.

Timelines for Provision of the IHA

An IHA must be scheduled and completed by PCPs as follows:

1. IHA will be conducted with all members within 120 days of initial enrollment unless excepted as noted in "Excluded Members" below; or documented within the past 12 months prior to member's enrollment, and the PCP determines that the Member's medical record contains complete and current information consistent with the Alliance assessment.

2. For members under the age of 18 months, the IHA will be completed within 120 calendar days following the date of enrollment or within the periodicity timeline established by the American Academy of Pediatrics (AAP) for ages two and younger, whichever is less.

3. If a member requests, or the Alliance initiates a change in PCP assignment within the first 120 days of enrollment, and the IHA has not yet been completed, the IHA must be completed by the newly assigned PCP within the established timeline for new members.

4. The Alliance ensures that subcontracted provider organizations selected or assigned to a member receive timely notification of a member's effective date of enrollment to allow scheduling and completion of the IHA within the required timeframe.

5. The effective date of enrollment is defined as:
    a. The first of the month following notification from DHCS that the member is eligible to be an Alliance member, the member is not on "hold" status, and capitation will be paid.
    b. For infants born to Alliance members, the effective date of enrollment is the date of birth. The Alliance covers the infant under the mother's enrollment from date of birth through the last day of the following month.
    c. In cases of retroactive enrollment, the effective date will be the date the Alliance receives notification of the member's enrollment.

Codes that qualify for IHA:

Provider	CPT Code	Description
PCP	99201 – 99205, 99461, G0438, Z1016	Office or other outpatient visit for the evaluation and management of new patient
PCP	99211-99215, G0439, Z00.01, Z00.110, Z00.111, Z00.8, Z02.1, Z02.3, Z02.5	Office or other outpatient visit for the evaluation and management of established patient with PCP but new to the Alliance
PCP	99381-99387	Comprehensive Preventive Visit and management of a new patient
PCP	99391-99397	Comprehensive Preventive Visit and management of an established patient with PCP but new to the Alliance
OB/Gyn	59400, 59425, 59426, 59430, 59510, 59610, 59618, Z1000, Z1008, Z1020,	Under Vaginal Delivery, Antepartum and Postpartum Care Procedures, Under Cesarean Delivery Procedures, Under Delivery Procedures After Previous Cesarean Delivery, Under Delivery Procedures After Previous Cesarean Delivery

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Provider	CPT Code	Description
	Z1032, Z1034, Z1036, Z1038	
Behavioral Health	96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)

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Excluded Members:

Individual members may be excluded from the IHA requirement under the following circumstances, and only if documented in the medical record:

1. All elements of the IHA were completed within the 12 months prior to enrollment, and the member's primary care services provider determines the requirements for documentation of the IHA are met.
2. New members who choose their current PCP as their new plan PCP provider, an IHA must still be ~~have an IHA~~ completed within 120 days enrollment. ~~.~~ ~~Relevant history from the patient's chart can be included, but PCPs must conduct an updated physical exam if the patient has not had a physical exam within 12 months of enrollment.~~
3. New members who are not continuously enrolled with the Alliance for 120 days.
4. ~~—~~Members, including emancipated minors, or a member's parent(s) or guardian(s), who refuses an IHA. In this case, a statement signed by the member must be documented in the member's medical record. If the member or the party legally responsible for the member refuses to sign a refusal statement, the verbal refusal of services will be noted in the medical record.

~~5.~~4.~~The member was dis-enrolled from the plan before an IHA could be performed.~~

~~6.~~5.The member missed a scheduled PCP appointment and **TWO** additional documented attempts to reschedule have been unsuccessful. If these efforts prove to be unsuccessful, the documentation must include at least the following:

   a. One attempt to contact member by phone.
   b. One attempt to contact member by letter or postcard sent to the address in the Alliance's records
   c. The Alliance's good faith effort to update the member's contact information.
   d. Attempts to perform the IHA at subsequent member office visit(s).

Provider ~~Training~~Communication

~~1. The Alliance trains our network providers and their staff regarding documentation of the IHA or reasons IHAs were not completed, timelines for performing IHAs and procedures to assure that IHAs are scheduled and members contacted about missed IHA appointments.~~

~~2.~~1.The Alliance incorporates IHA requirements in the~~trains providers through the~~ new provider orientation, the Provider Manual, fax blasts, regular primary care visits (by

provider representative), during Facility Site Reviews, and provider meetings/webinars.

Informing Members

1. The Alliance informs members about the IHA through the Evidence of Coverage; welcome letters, videos on our website, and member outreach. ~~outreach through interactive voice response (IVR).~~
2. Member information on the IHA includes:
    a. The availability of the IHA for all members
    b. Instructions on how to arrange for an IHA appointment within the appropriate timelines.
    c. The importance of keeping the IHA and other appointments.
    d. Member rights, including providing the member the results of the IHA.'

~~d.~~3. The Alliance makes reasonable attempts (~~maybe~~ a minimum of two outreach recommended) to contact ~~a~~ members to schedule IHA.

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Compliance with IHA:

1. Monthly, the Alliance pulls claims and encounters with specific visit codes listed above, for primary care providers to identify the percentage of their newly and reassigned assigned members who had a visit within 120 days of being assigned.

2. An Alliance Facility Site Review (FSR) Nurse routinely reviews and validates medical records for compliance with IHA standards as part of the triennial FSR process. The FSR Nurse ensures that 30% of medical records selected for review are for members eligible for an IHA (e.g., those with an effective date within the review period who have been a member for 120 days or longer). Records are determined to be compliant if all of the following criteria are met:
    a. The member had a PCP visit within the first 120 days of enrollment or documented within the 12 months prior to Alliance enrollment, and
    b. During the encounter and subsequent encounters, the IHA elements listed above were completed. ~~-~~
    c. If IHA was not completed, FSR Nurse will review documentation of the attempts made to contact members.
    ~~b.~~d. Failure to complete IHA or provide evidence of outreach attempts can result in a Corrective Action Plan (CAP).
    ~~c. The member was referred for applicable preventative services (e.g. colorectal cancer screening), and~~
    ~~d. The member's record includes a Staying Healthy Assessment questionnaire as appropriate for their age.~~

3. Quarterly results and reports are reviewed. Opportunities for improvement are discussed and aggregated results are annually shared with the Quality Improvement Health Equity ~~Health Care Quality~~ Committee (QIHEC).
4. The Alliance shall cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the findings

Collaboration

or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. The Alliance ensures that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

5. In the absence of risk factors and the need for immediate follow-up, core preventive services for the IHA for adults should be offered in the frequency required by the USPSTF Guide to Clinical Preventive Services
6. In the absence of risk factors and the need for immediate follow-up, core preventive services for the IHA for the pediatric population should be offered in the frequency required by the American Academy of Pediatrics (AAP)/Bright Futures age-specific guidelines
7. For newly pregnant women, Alliance will refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c).
8. Alliance will report to the immunization registry(ies) established in the service area as part of the Statewide Immunization Information System, following the Member's IHA and all other health care visits which result in an immunization.

Monitoring:

The Quality Improvement (QI) Department will ~~review at least 30 (thirty) at random records~~conduct a chart review audit of members who have been with the plan for 120 days and have had at least one provider visit. This will be done at ~~minimum~~a minimum annually. The purpose of these reviews will be to determine if all components of the IHA ~~has~~have been completed, and whether the completion followed the policy guidelines. Providers who fail to complete all elements of the IHA are notified and offered education on meeting the IHA requirements. If there are noted trends by a provider in f~~F~~ailure to meet all of the IHA requirements may result in the issuance of a Corrective Action Plan (CAP).

Data Sharing

1. ~~When necessary, T~~the Alliance shares IHA data with providers, subcontractors, and other sub-plan entities to facilitate care coordination for their members.

DEFINITIONS / ACRONYMS

American Academy of Pediatrics (AAP)
Facility Site Review (FSR)
Initial Health Appointment (IHA)
~~Individual Health Education Behavioral Assessment (IHEBA)~~
Primary Care Physician (PCP)
U.S. Preventive Services Task Force (USPSTF)

AFFECTED DEPARTMENTS/PARTIES

Medical Services, Quality Improvement

RELATED POLICIES AND PROCEDURES

APL 22-030
~~HED-008 – Staying Healthy Assessment (IHEBA)~~

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

~~DHCS Staying Healthy Assessment Questionnaires: http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx~~

REVISION HISTORY

12/17/2015, 8/29/2016, 1/04/2017, 4/12/2018, 11/15/2018, 1/16/2020, 11/19/2020, 3/21/2023, 1/16/2024

REFERENCES

Title 42, Section 438.208
Alameda Alliance Provider Manual

MONITORING

This Policy will be reviewed annually to ensure compliance with regulatory and contractual requirements. On review of this P&P, codes will also be re-evaluated and validated.

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ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	QI-125
Policy Name	Blood Lead Screening for Children
Department Name	Quality Management
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Quality
Line(s) of Business	Medi-Cal
Effective Date	7/18/2019
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

This policy and procedure outlines the process for meeting compliance with State and Federal regulations for blood lead screening and reporting requirements for Medi-Cal managed care health plans.

Per federal law regulations (42 U.S. Code Section 1396d(r)), States must screen children enrolled in Medi-Cal for elevated blood lead levels (BLLs) as part of required prevention services offered through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. Alameda Alliance for Health (the Alliance) must cover and ensure the provision of blood lead screenings in accordance with California state regulations. These regulations outline specific responsibilities of providers (doctors, nurse practitioners, and physician's assistants) conducting periodic health care assessments on children between the ages of six months and six years that must be in compliance with the clinical guidelines as outlined by the California Department of Public Health's California Childhood Lead Poisoning Prevention Branch (CLPPB).

PROCEDURE

The Alliance is required to ensure its contracted providers (i.e. physicians, nurse practitioners, and physician's assistants), who perform periodic health assessments on children between the ages of six months to six years (i.e. 72 months), comply with current federal and state laws and industry guidelines for health care providers issued by CLPPB, including any future updates or amendments.

The Alliance ensures its contracted providers are educated on the screening requirements below and will meet the following guidelines:

1. Provides oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that,

at a minimum, includes information that children can be harmed by exposure to lead. This anticipatory guidance must be performed at each periodic health assessment, starting at 6 months of age and continuing until 72 months of age.

2. Perform BLL testing on all children in accordance with the following:
    a. At 12 months and at 24 months of age.
    b. When the provider performing a periodic health assessment becomes aware that a child 12 to 24 months of age has no documented evidence of BLL test results taken at 12 months of age or thereafter.
    c. When the provider performing a periodic health assessment becomes aware that a child 24 to 72 months of age has no documented evidence of BLL test results taken when the child was 24 months of age or thereafter.
    d. Whenever the health care provider performing a periodic health assessment of a child 12 to 72 months of age becomes aware that a change in circumstances has placed the child at increased risk of lead poisoning, in the professional judgement of the provider.
    e. When requested by the parent or guardian.
    f. The provider is not required to perform BLL testing if:
        i. A parent or guardian of the child, or other person with legal authority to withhold consent, refuses to consent to the screening.
        ii. If in the professional judgement of the provider, the risk of screening poses a greater risk to the child's health than the risk of lead poisoning.
        iii. Providers must document the reasons for not screening in the child's medical record.

Screenings may be conducted using either the capillary (finger stick) or venous blood sampling methods. The venous method is preferred because it is more accurate and less prone to contamination. All confirmatory and follow-up BLL testing must be performed using blood samples taken through the venous blood sampling method.

Since no level of lead in the body is known to be safe and clinical guidelines are subject to change, the Alliance will ensure its contracted providers follow the CLPPB guidelines when interpreting BLLs and determining appropriate follow-up activities by its monitoring activities. The Alliance will provide its contracted providers with the current CLPPB guidelines to ensure providers are compliant with the federal guidelines. When there is a discrepancy in requirements between State requirements and CLPPB guidelines, the Alliance will ensure its contracted providers follow CLPPB guidelines.

The Alliance will provide its contracted providers education materials to ensure they are aware of the appropriate Common Procedure Terminology (CPT) coding for blood lead screenings. These CPT codes outlined by the Alliance will be monitored to ensure providers are compliant in providing screening services and reporting the appropriate CPT codes to the Alliance through the standard encounter data file formatting requirements. The Alliance along with its contracted providers and subcontractors are required to submit complete, accurate, reasonable, and timely encounter data consistent with the State requirements.

The Alliance will also ensure its contracted providers, including laboratories, performing blood lead analysis on blood specimens drawn in California to electronically report all results to CLPPB, along with specified patient demographic, ordering physician, and analysis data on each test performed. The Alliance will ensure its applicable contracted providers are educated and

comply with the reporting requirements for blood lead results to CLPPB.

REVISION HISTORY

7/18/2019, 11/19/2020, 11/18/2021, 03/21/2023

REFERENCES

DHCS All Plan Letter 20-016 Blood Lead Screening of Young Children
DHCS All Plan Letter 19-010 Requirements for Coverage of EPSDT Services for

MONITORING

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

The Alliance will ensure its contracted providers, delegates, and subcontractors comply with blood lead screening and reporting requirements by monitoring encounter data submissions and periodic medical record review of assessments.

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

AFFECTED DEPARTMENTS

Utilization Management Provider Services

POLICY AND PROCEDURE

Policy Number	QI-125
Policy Name	Blood Lead Screening for Children
Department Name	Quality Management
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Quality
Line(s) of Business	Medi-Cal
Effective Date	7/18/2019
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	2/17/2023
Compliance Committee Approval Date	TBD~~03/21/2023~~

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1.

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    d. Whenever the health care provider performing a periodic health assessment of a child 12 to 72 months of age becomes aware that a change in circumstances has placed the child at increased risk of lead poisoning, in the professional judgement of the provider.
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REVISION HISTORY

7/18/2019, 11/19/2020, 11/18/2021, 03/21/2023

REFERENCES

DHCS All Plan Letter 20-016 Blood Lead Screening of Young Children
DHCS All Plan Letter 19-010 Requirements for Coverage of EPSDT Services for

MONITORING

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

~~The Alliance will ensure its contracted providers, delegates, an~~d subcontractors comply with blood lead screening and reporting requirements by monitoring encounter data submissions and periodic medical record review of assessments.

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

AFFECTED DEPARTMENTS

Utilization Management Provider Services

REVISION HISTORY

7/18/2019, 11/19/2020, 11/18/2021, 03/21/2023

REFERENCES

DHCS All Plan Letter 20-016 Blood Lead Screening of Young Children
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MONITORING

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

The Alliance will ensure its contracted providers, delegates, and subcontractors comply with blood lead screening and reporting requirements by monitoring encounter data submissions and periodic medical record review of assessments.

~~RELATED POLICIES AND PROCEDURES~~

~~QI 101 Quality Improvement Program~~

~~RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS~~

~~None~~

~~AFFECTED DEPARTMENTS~~

~~Utilization Management~~
~~Provider Services~~

POLICY AND PROCEDURE

Policy Number	UM-002
Policy Name	Coordination of Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Senior Director, Health Care Services
Lines of Business	All
Effective Date	11/21/2006
Approval Date	~~02/21/2023~~TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) ensures that it provides comprehensive medical case management and basic population health management (BPHM) to ~~each of its~~all members in accordance with 42 CFR section 438.208. BPHM and c~~C~~omprehensive medical case management include care coordination for medically necessary services provided to members within and outside of the Alliance's provider network.~~,~~ ~~Based~~ based on the individual member's needs.~~,~~ The Alliance is the primary provider of such medical services except for those services that have been expressly carved-out. ~~The Alliance provides case management and care coordination to ensure that Members under the age of 21 can access Medically Necessary Early and Periodic Screening, Diagnostic Services, (EPSDT), also known as Medi-Cal for Kids & Teens services as determined by the Alliance Provider. For example, when school is not in session, the Alliance covers medically necessary EPSDT/Medi-Cal for Kids & Teens services that were being provided by the LEA program when school was in session. Where another entity, such as a Local Education Agency (LEA), RC, or local governmental health program, has overlapping responsibility for providing services to a Member under the age of 21, the Alliance does the following:~~

~~• Assess what level of EPSDT/Medi-Cal for Kids & Teens medically necessary services the Member requires.~~

~~• Determine what level of service (if any) is being provided by other entities, and~~

~~• Coordinate the provision of services with the other entities to ensure that the Alliance and the other entities are not providing duplicative services, and that the Member is receiving all medically necessary EPSDT/Medi-Cal for Kids & Teens services in a timely manner.~~

A. Delivery of Primary Care

The Alliance ensures that members have an ongoing 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,

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mental health, substance use disorder (SUD), dementia, long-term services and supports (LTSS), palliative care, vision, oral health, and pharmacy needs. The Alliance 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.

~~A.~~B. Primary Care ~~Physician~~ Provider (PCP) Role

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. The Alliance ensures that each member is engaged with their assigned PCP, who plays a key role in coordination and continuity of care~~Continuity and Coordination of care is ensured through the Primary Care Physician (PCP) who is formally designated as having primary responsibility for coordinating the member's overall health care~~. The PCP has the responsibility and authority to direct and coordinate the members' services. These responsibilities include: 1) Act as the primary case manager for all assigned members, 2) Assess the acute, chronic, and preventive needs of each member, ~~and~~ 3) Ensure members receive all needed preventive services, and 4) Provide members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes.

~~Employ disease management protocols to manage member's chronic health conditions.~~

~~B. Delivery of Primary Care~~

~~Establishment of an ongoing relationship between the member and their chosen Primary Care Physician 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. Primary care services will be available according to the health plan's established access and availability standards.~~

C. Coordination of Services

The Alliance partners with primary care and other delivery systems to coordinate health and social services between settings of care; across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services); with external entities outside of the provider network; and with Community Supports and other community-based resources, even if they are not covered services, to guarantee members' needs are addressed and to mitigate impacts of SDOH.

~~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.~~

Members are included in the planning and implementation of their care, with special emphasis on those members with mental health or substance abuse 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 adults) may be represented by parents, guardians, other family members or conservators, as appropriate, and in accordance with the member's wishes.

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. 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.

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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 covered services as well as services not covered.

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The Alliance offers care coordination for the following services:

- Appointments with specialists to meet time and distance and timely access standards
- Services with out of network (OON) providers
- Establishment of a member specific letter of agreement (LOA) with providers/specialists to meet time and distance and timely access standards
- Behavioral health care
- Alcohol and substance use disorder treatment services
- Children with special health care needs
- Early and Periodic Screening Diagnostic and Screening (EPSDT) service providers
- California Children's Services (CCS)
- Services for persons with developmental disabilities (Regional Center)
- Early intervention service with the Early Start Program
- Local Education Agency Services (LEA)
- School linked CHDP services
- HIV/AIDS waiver program
- Dental services
- Direct observed therapy (DOT) for treatment of Tuberculosis
- Women, Infants, and Children (WIC) Supplemental Nutrition program
- Excluded services requiring member disenrollment
- Waiver Program
- Transportation to appointments as needed for both In-Network and OON Providers to meet time and distance and timely access standards.
- Private Duty Nursing and CBAS services

1. Coordination of Services with Out-of-Network Providers

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~~a.~~ The Alliance identifies members who may need or who are receiving services from out of plan providers and/or programs in order 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.

- The LOA is offered at no less ~~that~~than the Medi-Cal Fee-For-Service rate, is agreed upon by the Alliance and the provider, and is made within the most recent year.
- Members are provided information on how to obtain out of network care in the Member's Handbook/Evidence of Coverage. When an authorization request for care by an out of network provider is approved, the member is informed in the Approval Letter. When a 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.

2. Coordination of Behavioral Health Care

a. Alameda Alliance for Health collaborates with its behavioral health specialists to identify opportunities to improve coordination of behavioral health care with general medical care that may include but is not limited to collaboration between organization and behavioral health specialists. The Alliance Policy *UM-012 Care Coordination - Behavioral Health* describes the process of care coordination for behavioral health services.

3. Coordination of Alcohol and Substance use Disorder Treatment Services

a. PCPs are responsible for identifying Members with active or potential substance abuse problems. Once Members are identified, PCPs are responsible for providing services for the substance abuse problem within their scope of practice (counseling and/or treatment) and for performing the appropriate medical work-up given the nature of the substance abuse problem. PCPs are also responsible, with the assistance of the Alliance, for referring Members with substance abuse problems to an appropriate treatment practitioner or county department. The Alliance Policy *UM-013 Care Coordination - Substance Abuse* describes the process of care coordination for alcohol and substance use disorder treatment services.

4. Children with Special Health Care Needs

a. The Alliance will assist with referrals/authorizations and care coordination to ensure that members receive the care appropriate for their medical, mental, or physical condition. The Alliance has individual policies describing the process of care coordination for children with special healthcare needs.

5. Early and Periodic Screening Diagnostic and Screening (EPSDT) service providers

The Alliance provides case management and care coordination to ensure that Members under the age of 21 can access Medically Necessary Early and Periodic Screening, Diagnostic Services, (EPSDT), also known as Medi-Cal for Kids & Teens services as determined by the Alliance Provider. For example, when school is not in session, the Alliance covers medically necessary EPSDT/Medi-Cal for Kids & Teens services that were being provided by the LEA program when school was in session. Where another entity, such as a Local Education Agency (LEA), RC, or local governmental health program, has overlapping responsibility for providing services to a Member under the age of 21, the Alliance does the following:

- Assess what level of EPSDT/Medi-Cal for Kids & Teens medically necessary services the Member requires,
- Determine what level of service (if any) is being provided by other entities, and
- Coordinate the provision of services with the other entities to ensure that the Alliance and the other entities are not providing duplicative services, and that the Member is receiving all medically necessary EPSDT/Medi-Cal for Kids & Teens services in a timely manner.

~~5.~~6. California Children's Services (CCS)

a. At AAH, CCS is a service carved out of the DHCS Contract for CCS-eligible conditions. If a Member of AAH is under the age of 21 has a CCS eligible condition, then the Member may obtain treatment related to the CCS-eligible condition from CCS if the Member enrolls in CCS. PCPs and

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specialists are responsible for early identification of Members that may have eligible CCS conditions. Medically necessary health care services will be administered throughout the referral process with the Alliance, regardless of whether or not the child is accepted into the CCS program (e.g., Early and Periodic Screening, Diagnosis and Treatment (EPSDT) ~~Supplemental~~ Services for Medi-Cal Members, also known as Medi-Cal for Kids and Teens.). The Alliance will consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU. The Alliance Policy *UM-008 Coordination of Care - California Children's Services* describes the process of care coordination with CCS.

~~6.~~7. Services for Persons with Developmental Disabilities

~~a.~~ 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. 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. ~~Refer~~ The Alliance Policy ~~*to UM-020*~~*CM-029 Developmental Disabilities* ~~*y*~~ describes the process of care coordination with the Regional Center.

~~7.~~8. Early Intervention Services

~~a.~~ Primary Care Providers (PCPs) are responsible for assessing children's developmental status during Well Child exams, or at other medical encounters as appropriate. Children from birth to 36 months old identified at risk for, or suspected of having, a developmental disability or delay must be referred to the Regional Center of the East Bay (RCEB) for evaluation for the Early Start Program. The Alliance will collaborate with Regional Center of the East Bay (RCEB) or local Early Start Program in determining the medically necessary diagnostic and preventive services and treatment plans for members participating in the Early Start program. The Alliance Policy ~~*UM*~~*CM-~~021~~ 030 Early Start* describes the process of care coordination with the Early Start Program.

~~8.~~9. Local Education Agency Services

~~a.~~ 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. On an as needed basis, the Alliance will work with the PCP to coordinate care for a Member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the Individual Education plan developed by the LEA, with the PCP's participation. The Alliance Policy ~~*UM-027*~~*CM-032 Care Coordination - Local Education Agency Services* describes the process of care coordination with the LEA.

~~9.~~10. School Linked CHDP Services

~~a.~~ All pediatric members will be assigned to a Primary Care Provider (PCP) who will be their "medical home." The Alliance will coordinate with school-linked CHDP Services in order to assure access for child and adolescent members to preventive and early intervention services. The Alliance Policy ~~*UM*~~*CM-03~~19~~ School linked CHDP Services* describes the process of care coordination with school linked CDHP services.

~~10.~~11. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)

~~11.~~ Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered by Managed Medi-Cal. However, contracted PCPs and specialists (practitioners) have the responsibility to identify and refer Medi-Cal Managed Care Plan (MCP) members to an HIV/AIDS waiver program if they meet criteria. The Alliance Policy ~~*UM-017*~~*CM-033 Home and Community Based Services (Waiver Programs) - DDS* describes the process of care coordination for these services.

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12. Dental Services

a. Dental services are not covered by managed Medi-Cal. However, the Alliance will ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. The Alliance Policy *UM-024 Care Coordination - Dental Services* describes the process of care coordination for dental services.

13. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

a. DOT is offered by the local health departments (LHDs) and is not covered by Managed Medi-Cal. PCPs will assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis therapy. The Alliance Policy *UM-023 Communicable Disease Reporting and Services* describes the process of care coordination for treatment of TB.

14. Women, Infants, and Children Supplemental Nutrition Program

a. 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 for WIC services. The Alliance Policy *UM-030 Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)* describes the process of care coordination for these services.

15. Excluded Services Requiring Member Disenrollment

a. For services related to long-term care, the Alliance will initiate the disenrollment process. The Alliance Policy *UM-010 Coordination of Care - Long Term Care* describes the process of care coordination for patients admitted to long-term care.

16. Waiver Program

a. Members who may qualify for one of the Waiver Programs will be identified by their PCP, with Utilization Management (UM) Department support, based on their diagnosis and need for a specific level of care. The Alliance Policy ~~*UM*~~*CM-~~017~~ 033 Home and Community Based Services (Waiver Programs)-DDS* describes the process of care coordination with these waiver programs.

17. Transportation Services

a. The Alliance will assist members to obtain transportation to services as needed to assure that members can obtain care within the time and distance and timely access standards.

18. Private Duty Nursing and CBAS services

Private Duty Nursing and 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 *CM-019 Private Duty Nursing Case Management for Members under the age of 21* and CBAS policies.

D. Authorization of Services

Services should be medically necessary and recommended by the PCP or the Specialty Care Provider (SCP). Members have a right to request any covered services, whether or not the service

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has been recommended by the PCP/SCP. The services must be approved through a utilization management system (either the health plan or the delegated Medical Group/IPA) based on medical~~ly~~ necessity.

PROCEDURE

I. Coordination Process

1. The patient'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.
   ~~a)~~ Includes any documentation of care/services provided regarding mental health and/or substance abuse, providing the member has authorized the mental health/substance abuse provider to disclose that information.
   a)

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b) Documentation of referral/receipt of long-term supports and services.
c) Documentation may be direct or consist of summary, consultation letters, discharge notes and progress notes submitted by outside providers.
d) When a member chooses a new PCP within the same network, the medical records are transferred to the new provider in a timely manner.

2. Continuity of care issues may include but are not limited to:
   a) Ongoing DME in use in the member's home by the member (i.e., wheelchair, hospital bed, oxygen, etc.);
   b) Open authorizations to specialty or diagnostic testing services (i.e., MRI, PT, Specialty consultation/follow-up visits, etc.);
   c) 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.;
   d) Disease management goals, interventions, and outcomes.
   e) Pharmacy utilization issues (i.e., non-formulary medications, poly-pharmacy issues; contraindicated medications, etc.);
   f) Other issues (i.e., member out of area 3 months out of the year, member resides in a custodial care facility, etc.).

3. 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 ~~xyz~~X drug), etc.).

4. Urgent and Emergency Care Services.
   a) When urgent services are not available with the member's PCP, the PCP arranges/refers the member to an appropriate source for care within the network.
   b) 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.
   c) Emergency services are available through the Emergency Medical Services system (911) or through an emergency room (see Emergency Services Policy) either within or outside the service area, and without prior authorization.

5. 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.
   a) 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.
   b) 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.
   c) This information should include:
      i) The member's condition
      ii) Any proposed treatments or procedures and alternatives
      iii) The benefits, drawbacks, and likelihood of success of each option
      iv) The possible consequences of refusal or non-compliance with a recommended course of care.

~~6.~~ Members who are unable or unwilling to participate in their own care will be assessed through Care Coordination/Utilization Management, appropriately counseled, and

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6. of their health care options in order to be ~~channeled~~ referred into the most appropriate long-term services and supports, ~~and services~~ and other community agencies.

7. The areas where members need to be able to fully participate in their care include, but are not limited to, the following:
   a) Self-Care
   b) Medication Management
   c) Disease Management
   d) Use of medical equipment
   e) Potential complications and when those should be reported to providers
   f) Scheduling of follow-up services
   g) Member education, especially as it relates to discharge planning

8. The Alliance implements information-sharing processes and referral support infrastructure. All member information will be kept confidential. The Alliance:
   a) Ensures that providers furnishing services to members maintain and share, as appropriate, members' medical records in accordance with professional standards and state and federal law.
   ~~8~~b) Facilitates exchange of necessary member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable.

9. The Alliance maintains processes to ensure no duplication of services occurs.

~~9~~10. Care coordination consists of health care professionals with appropriate experience and/or special education related to the targeted population.
   a) Coordinators serve as a resource both internally and throughout the provider network.
   b) Education on health promotion and preventive services is prepared for distribution to members and their providers on an ongoing basis.
   c) Disease management programs integrate the full range of services available from the plan and within the community.

Whenever possible, services are coordinated through both contracted and non-contract providers in the service area to ensure continuity of care and integration of services with long-term ~~supports and~~ services and supports, and other community and social service programs.

11. See Attachments for Care Coordination and OON/LOA Workflows.

~~The Alliance provides resources to network providers for referrals in order to ensure that BPHM is provided to all members. The Alliance:~~
   ~~Maintains a system to electronically track and monitor provider referrals not requiring Prior Authorization, including referrals for care management services, and the outcomes of referrals.~~
   ~~Provides access to a current and continuously updated community resource~~

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~~directory to providers.~~

- ~~Provides a toll-free telephone number for providers to obtain assistance in arranging referrals.~~
  - ~~Telephone referral assistance addresses referrals for mental health and SUD treatment, developmental services, dementia, palliative care, dental, personal care services, and LTSS~~
  - ~~The Alliance communicates the availability of telephone referral assistance by providing the toll-free number on the homepage of the website and in materials supplied to providers, including the Provider Manual.~~

12. For the following entities, the Alliance will establish a closed loop referral process.
    a) CalFresh
    b) California Work Opportunity and Responsibility to Kids (CalWORKs)
    c) CCS
    d) CHW services, and services provided by peer counselors, and local community organizations.
    e) Community Supports
    f) Dental providers
    g) Developmental Services (DD)
    h) ECM Community Supports
    i) IHSS & HCBS: County and social services agencies and waiver agencies for IHSS and other home and community-based services (HCBS)
    j) Specialty mental health services, (in the Alliance network, Alameda County Behavioral Health, or Medi-Cal FFS delivery system) to ensure the members receive timely mental health services, without delay regardless of where they initially seek care, in accordance with "No Wrong Door" policy
    k) SUD: Appropriate delivery system for SUD services
    l) Supplemental Security Income (SSI)
    m) Women, Infants and Children (WIC)
    n) All other programs requiring Memorandums of Understanding (MOUs)

13. The Alliance will coordinate warm handoffs with local health departments and other public benefit programs, starting January 2025.

14. The Alliance enters into MOUs with various programs to ensure coordination of care in alignment with the 2024 DHCS contract requirements.

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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 Alliance Policy *QI-111 Delegation Management and Oversight*~~CMP-019 for monitoring of delegation oversight~~.

DEFINITIONS

BPHM – Basic Population Health Management
~~**CalWorks**~~**CalWORKs** - California Work Opportunity and Responsibility to Kids
CBAS – Community-Based Adult Services
CCS – California Children's Services
CHDP – Child Health and Disability Prevention Program
CHW – Community Health Worker
DDS – Department of Developmental Services
ECM – Enhanced Care Management
HCBS – Home and Community Based Services
IHSS – In-Home Supportive Services
LEA – Local Education Agencies
LOA – Letter of agreement
LTSS – Long-term services and supports
MOU – Memorandum of Understanding
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)
~~None.~~

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CM-029 Developmental Disabilities
CM-030 Early Start
CM-031 School Linked CHDP Services
CM-032 Care Coordination - Local Education Agency Services
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-008 Coordination of Care - California Children's Services (CCS)
UM-010 Coordination of Care - Long Term Care
UM-012 Care Coordination - Behavioral Health
UM-013 Coordination of Care - Substance Abuse
UM-016 Transportation Guidelines

UM-023 Communicable Disease Reporting and Services
UM-024 Care Coordination – Dental Services
UM-030 Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)

~~QI 111 Delegation Management and Oversight Management~~
~~QI 135 Early and Periodic Screening and Diagnostic (EPSDT) Services~~
~~CRE 009 Ongoing Monitoring of Practitioners PCP, Specialist and Delegated Provider Contracts Provider Manual Sections 5, 6, 8 and 11~~
~~UM 008 Coordination of Care California Children's Services (CCS)~~
~~UM 010 Coordination of Care Long Term Care~~
~~UM 012 Care Coordination Behavioral Health~~
~~UM 013 Coordination of Care Substance Abuse~~
~~UM 016 Transportation Guidelines~~
~~UM 018 Targeted Case Management (TCM) and Early and Periodic Screening and Diagnostic Services (EPSDT)~~
~~UM 019~~CM 031 ~~School Linked CHDP Services~~
~~UM 020~~CM 029 ~~Developmental Disabilities~~
~~UM 021~~CM 030 ~~Early Start~~
~~UM 027~~CM 032 ~~Care Coordination Local Education Agency Services~~

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RELATED WORFLOW DOCUMENTS OR OTHER ATTACHMENTS

UM-002 Attachment 1: Care Coordination Workflow
UM-002 Attachment 2: Case Management Workflow for OON -Providers/Service
UM-002 Attachment 3: UM OON LOA Workflow

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REVISION HISTORY

1/1/2008, 7/28/2008, 10/28/2009, 9/07/2012, 04/17/2013, 04/07/2014, 01/01/2016, 12/15/2016, 04/16/2019, 5/21/2020, 3/22/2022, 02/21/2023

REFERENCES

1. DHCS Contract, Exhibit A, Attachment 11, Provisions 1 and 2
2. 42 CFR Section 422.112(b)(3)
3. 42 CFR Section 438.208
4. 45 CFR Sections 160 and 164(a) and (e)
5. DHCS 2024 MCP Contract
~~1. DHCS Contract, Exhibit A, Attachment 11, Provisions 1 and 2~~

~~2. Title 42, CFR, Section 422.112(b)(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 Healthcare Quality Committee annually.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-002
Policy Name	Coordination of Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	All
Effective Date	11/21/2006
Approval Date	TBD

POLICY STATEMENT

I. Alameda Alliance for Health (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 medical case management include care coordination for medically necessary services provided to members within and outside of the Alliance's provider network, based on the individual member's needs. The Alliance is the primary provider of such medical services except for those services that have been expressly carved-out.

A. Delivery of Primary Care

The Alliance ensures that members have an ongoing 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. The Alliance 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.

B. Primary Care Provider (PCP) Role

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. The Alliance ensures that each member is engaged with their assigned PCP, who plays a key role in coordination and continuity of care. The PCP has the responsibility and authority to direct and coordinate the members' services. These responsibilities include: 1) Act as the primary case manager for all assigned members, 2) Assess the acute, chronic, and preventive needs of each member, 3) Ensure members receive all needed preventive services, and 4) Provide members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes.

C. Coordination of Services

The Alliance partners with primary care and other delivery systems to coordinate health and social services between settings of care; across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services); with external entities outside of the provider network; and with Community Supports and 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).

Members are included in the planning and implementation of their care, with special emphasis on those members with mental health or substance abuse 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 adults) may be represented by parents, guardians, other family members or conservators, as appropriate, and in accordance with the member's wishes.

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. 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.

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 covered services as well as services not covered.

The Alliance offers care coordination for the following services:

1. Coordination of Services with Out-of-Network Providers/ Letter of Agreement (LOA)

    a) The Alliance identifies members who may need or who are receiving services from out of plan providers and/or programs in order 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.
        i. The LOA is offered at no less than the Medi-Cal Fee-For-Service rate, 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.
        ii. Members are provided information on how to obtain out of network care in the Member's Handbook/Evidence of Coverage. When an authorization request for care by an out of network provider is approved, the member is informed in the Approval Letter. When a 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.

2. Coordination of Behavioral Health Care

    a) Alameda Alliance for Health collaborates with its behavioral health specialists to identify opportunities to improve coordination of behavioral health care with general medical care that may include but is not limited to collaboration between organization and behavioral health specialists. The Alliance Policy *UM-012 Care Coordination - Behavioral Health* describes the process of care coordination for behavioral health services.

3. Coordination of Alcohol and Substance Use Disorder Treatment Services

    a) PCPs are responsible for identifying Members with active or potential substance abuse 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.
    b) PCPs are also responsible, with the assistance of the Alliance, for referring Members with substance abuse problems to an appropriate treatment practitioner or county department. The Alliance Policy *UM-013 Care Coordination – Substance Abuse* describes the process of

care coordination for alcohol and substance use disorder treatment services.

4. Children with Special Health Care Needs

    a) The Alliance will assist with referrals/authorizations and care coordination to ensure that members receive the care appropriate for their medical, mental, or physical condition. The Alliance has individual policies describing the process of care coordination for children with special healthcare needs.

5. Early and Periodic Screening Diagnostic and Screening (EPSDT) service providers

    a) The Alliance provides case management and care coordination to ensure that Members under the age of 21 can access Medically Necessary Early and Periodic Screening, Diagnostic Services, (EPSDT), also known as Medi-Cal for Kids & Teens services as determined by the Alliance Provider. For example, when school is not in session, the Alliance covers medically necessary EPSDT/Medi-Cal for Kids & Teens services that were being provided by the LEA program when school was in session. Where another entity, such as a Local Education Agency (LEA), RC, or local governmental health program, has overlapping responsibility for providing services to a member under the age of 21, the Alliance does the following:
        i. Assess what level of EPSDT/Medi-Cal for Kids & Teens medically necessary services the Member requires,
        ii. Determine what level of service (if any) is being provided by other entities, and
        iii. Coordinate the provision of services with the other entities to ensure that the Alliance and the other entities are not providing duplicative services, and that the Member is receiving all medically necessary EPSDT/Medi-Cal for Kids & Teens services in a timely manner.

6. California Children's Services (CCS)

    a) At AAH, CCS is a service carved out of the DHCS Contract for CCS-eligible conditions. If a Member of AAH is under the age of 21, has a CCS eligible condition, then the Member may obtain treatment related to the CCS-eligible condition from CCS if the Member enrolls in CCS. PCPs and specialists are responsible for early identification of Members that may have eligible CCS conditions. Medically necessary health care services will be administered throughout the referral process with the Alliance, regardless of whether or not the child is accepted into the CCS program (e.g., Early and Periodic Screening,

Diagnosis and Treatment (EPSDT) Services for Medi-Cal Members. also known as Medi-Cal for Kids and Teens.). The Alliance will consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU. The Alliance Policy *UM-008 Coordination of Care - California Children's Services* describes the process of care coordination with CCS.

7. Services for Persons with Developmental Disabilities (Regional Center)

    a) 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. 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. The Alliance Policy *CM-029 Developmental Disabilities* describes the process of care coordination with the Regional Center.

    b) The Alliance is also responsible forauthorize a member's stay in an Intermediate Care Facility for the Developmentally Delayed (ICF/DD) homes following Alliance Policy- *LTC-002 LTC Authorization Criteria.*

8. Early Intervention Services with the Early Start Program

    a) Primary Care Providers (PCPs) are responsible for assessing children's developmental status during Well Child exams, or at other medical encounters as appropriate. Children from birth to 36 months old identified at risk for, or suspected of having, a developmental disability or delay must be referred to the Regional Center of the East Bay (RCEB) for evaluation for the Early Start Program.

    b) The Alliance will collaborate with Regional Center of the East Bay (RCEB) or local Early Start Program in determining the medically necessary diagnostic and preventive services and treatment plans for members participating in the Early Start program. The Alliance Policy *CM-030 Early Start* describes the process of care coordination with the Early Start Program.

9. Local Education Agency Services (LEA)

    a) 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. On an as needed basis, the Alliance will work with the PCP to coordinate care for a Member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the Individual Education plan developed by the LEA, with the PCP's participation. The Alliance Policy *CM-032 Care Coordination - Local Education Agency Services* describes the process of care coordination with the LEA.

10. School Linked CHDP Services

    a) All pediatric members will be assigned to a Primary Care Provider (PCP) who will be their "medical home." The Alliance will coordinate with school-linked CHDP Services in order to assure access for child and adolescent members to preventive and early intervention services. The Alliance Policy *CM-031 School linked CHDP Services* describes the process of care coordination with school linked CDHP services.

11. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver Program

    a) Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered by Managed Medi-Cal. However, contracted PCPs and specialists (practitioners) have the responsibility to identify and refer Medi-Cal Managed Care Plan (MCP) members to an HIV/AIDS waiver program if they meet criteria. The Alliance Policy *CM-033 Home and Community Based Services (Waiver Programs) - DDS* describes the process of care coordination for these services.

12. Dental Services

    a) Dental services are not covered by managed Medi-Cal. However, the Alliance will ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. The Alliance Policy *UM-024 Care Coordination - Dental Services* describes the process of care coordination for dental services.

13. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

    a) DOT is offered by the local health departments (LHDs) and is not covered by Managed Medi- Cal. PCPs will assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis therapy. The Alliance Policy *UM-023 Communicable Disease Reporting and Services* describes the process of care coordination for treatment of TB.

14. Women, Infants, and Children (WIC) Supplemental Nutrition Program

    a) 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 for WIC services. The Alliance Policy *UM-030 Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)* describes the process of care coordination for these services.

15. Waiver Programs

    a) Members who may qualify for one of the Waiver Programs will be identified by their PCP, with Utilization Management (UM) Department support, based on their diagnosis and need for a specific level of care. The Alliance Policy *CM-033 Home and Community Based Services (Waiver Programs)-DDS* describes the process of care coordination with these waiver programs.

16. Transportation Services

    a) The Alliance will assist members to obtain transportation to services as needed to assure that members can obtain care within the time and distance and timely access standards.

17. Private Duty Nursing and Community Based Adult Services (CBAS)

    a) Private Duty Nursing and 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 *CM-019 Private Duty Nursing Case Management for Members under the age of 21* and CBAS policies.

D. Authorization of Services

Services should be medically necessary and recommended by the PCP or the Specialty Care Provider (SCP). Members have a 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 (either the health plan or the delegated Medical Group/IPA) based on medical necessity.

PROCEDURE

I. Coordination Process

A. The patient'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.

1. Includes any documentation of care/services provided regarding mental health and/or substance abuse, providing the member has authorized the mental health/substance abuse provider to disclose that information.

2. Documentation of referral/receipt of long-term supports and services.

3. Documentation may be direct or consist of summary, consultation letters, discharge notes and progress notes submitted by outside providers.

4. 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 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.).

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.).

D. Urgent and Emergency Care Services.

1. 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.

2. Emergency services are available through the Emergency Medical Services system (911) or through an emergency room (see Emergency Services Policy) 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.

1. 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.

2. 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.

3. This information should include:
    a) The member's condition
    b) Any proposed treatments or procedures and alternatives
    c) The benefits, drawbacks, and likelihood of success of each option
    d) The possible consequences of refusal or non-compliance with a recommended course of care.

F. Members who are unable or unwilling to participate in their own care will be assessed through Care Coordination/Utilization Management, appropriately counseled, and given all of their health care options in order to be referred into the most appropriate long-term services and supports, and other community agencies.

G. The areas where members need to be able to fully participate in their care include, but are not limited to, the following:

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

H. The Alliance implements information-sharing processes and referral support

infrastructure. All member information will be kept confidential. The Alliance:

1. Ensures that providers furnishing services to members maintain and share, as appropriate, members' medical records in accordance with professional standards and state and federal law.

2. Facilitates exchange of necessary member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable.

I. The Alliance maintains processes to ensure no duplication of services occurs.

J. Care coordination consists of health care professionals with appropriate experience and/or special education related to the targeted population.

1. Coordinators serve as a resource both internally and throughout the provider network.

2. Education on health promotion and preventive 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 and within the community.

K. Whenever possible, services are coordinated through both contracted and non-contract providers in the service area to ensure continuity of care and integration of services with long-term services and supports, and other community and social service programs.

L. See Attachments for Care Coordination and OON/LOA Workflows.

M. For the following entities, the Alliance will establish a closed loop referral process.

1. CalFresh

2. California Work Opportunity and Responsibility to Kids (CalWORKs)

3. CCS

4. CHW services, and services provided by peer counselors, and local community organizations.

5. Community Supports

6. Dental providers

7. Developmental Services (DD)

8. ECM Community Supports

9. IHSS & HCBS: County and social services agencies and waiver agencies for IHSS and other home and community-based services (HCBS)

10. Specialty mental health services, (in the Alliance network, Alameda County Behavioral Health, or Medi-Cal FFS delivery system) to ensure the members receive timely mental health services, without delay regardless of where they initially seek care, in accordance with "No Wrong Door" policy

11. SUD: Appropriate delivery system for SUD services

12. Supplemental Security Income (SSI)

13. Women, Infants and Children (WIC)

14. All other programs requiring Memorandums of Understanding (MOUs)

N. The Alliance will coordinate warm handoffs with local health departments and other public benefit programs, starting January 2025.

O. The Alliance enters into MOUs with various programs to ensure coordination of care in alignment with the 2024 DHCS contract requirements.

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 Alliance Policy *QI-111 Delegation Management and Oversight*.

DEFINITIONS

BPHM – Basic Population Health Management
CalWORKs - California Work Opportunity and Responsibility to Kids
CBAS – Community-Based Adult Services
CCS – California Children's Services
CHDP – Child Health and Disability Prevention Program
CHW – Community Health Worker
DDS – Department of Developmental Services

ECM – Enhanced Care Management
HCBS – Home and Community Based Services
IHSS – In-Home Supportive Services
LEA – Local Education Agencies
LOA – Letter of agreement
LTSS – Long-term services and supports
MOU – Memorandum of Understanding
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

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CM-029 Developmental Disabilities
CM-030 Early Start
CM-031 School Linked CHDP Services
CM-032 Care Coordination - Local Education Agency Services
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-008 Coordination of Care - California Children's Services (CCS)
UM-010 Coordination of Care - Long Term Care
UM-012 Care Coordination - Behavioral Health
UM-013 Coordination of Care - Substance Abuse
UM-016 Transportation Guidelines
UM-023 Communicable Disease Reporting and Services
UM-024 Care Coordination – Dental Services
UM-030 Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)

RELATED WORFLOW DOCUMENTS OR OTHER ATTACHMENTS

UM-002 Attachment 1: Care Coordination Workflow
UM-002 Attachment 2: Case Management Workflow for OON Providers/Service
UM-002 Attachment 3: UM OON LOA Workflow

REVISION HISTORY

1/1/2008, 7/28/2008, 10/28/2009, 9/07/2012, 04/17/2013, 04/07/2014, 01/01/2016, 12/15/2016, 04/16/2019, 5/21/2020, 3/22/2022, 02/21/2023, 1/24/24

REFERENCES

1. DHCS Contract, Exhibit A, Attachment 11, Provisions 1 and 2
2. 42 CFR Section 422.112(b)(3)
3. 42 CFR Section 438.208
4. 45 CFR Sections 160 and 164(a) and (e)
5. DHCS 2024 MCP Contract

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-002
Policy Name	Coordination of Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	All
Effective Date	11/21/2006
Approval Date	~~02/21/2023~~TBD

POLICY STATEMENT

~~I.~~ Alameda Alliance for Health (the Alliance) ensures that it provides comprehensive medical case management and basic population health management (BPHM) to ~~each of its~~all members in accordance with 42 CFR section 438.208. BPHM and c~~C~~omprehensive medical case management include care coordination for medically necessary services provided to members within and outside of the Alliance's provider network.~~,~~ ~~Based~~ based on the individual member's needs.~~,~~ The Alliance is the primary provider of such medical services except for those services that have been expressly carved-out. ~~The Alliance provides case management and care coordination to ensure that Members under the age of 21 can access Medically Necessary Early and Periodic Screening, Diagnostic Services, (EPSDT), also known as Medi-Cal for Kids & Teens services as determined by the Alliance Provider. For example, when school is not in session, the Alliance covers medically necessary EPSDT/Medi-Cal for Kids & Teens services that were being provided by the LEA program when school was in session. Where another entity, such as a Local Education Agency (LEA), RC, or local governmental health program, has overlapping responsibility for providing services to a Member under the age of 21, the Alliance does the following:~~

~~I.~~ ~~• Assess what level of EPSDT/Medi-Cal for Kids & Teens medically necessary services the Member requires;~~

~~I.~~ ~~• Determine what level of service (if any) is being provided by other entities, and~~

~~I.~~ ~~• Coordinate the provision of services with the other entities to ensure that the Alliance and the other entities are not providing duplicative services, and that the Member is receiving all medically necessary EPSDT/Medi-Cal for Kids & Teens services in a timely manner.~~

A. Delivery of Primary Care

The Alliance ensures that members have an ongoing 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

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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. The Alliance 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.

~~A.~~B. Primary Care ~~Physician~~ Provider (PCP) Role

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. The Alliance ensures that each member is engaged with their assigned PCP, who plays a key role in coordination and continuity of care~~Continuity and Coordination of care is ensured through the Primary Care Physician (PCP) who is formally designated as having primary responsibility for coordinating the member's overall health care~~. The PCP has the responsibility and authority to direct and coordinate the members' services. These responsibilities include: 1) Act as the primary case manager for all assigned members, 2) Assess the acute, chronic, and preventive needs of each member, ~~and~~ 3) Ensure members receive all needed preventive services, and 4) Provide members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes.

~~Employ disease management protocols to manage member's chronic health conditions.~~

~~B. Delivery of Primary Care~~

~~Establishment of an ongoing relationship between the member and their chosen Primary Care Physician 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. Primary care services will be available according to the health plan's established access and availability standards.~~

C. Coordination of Services

The Alliance partners with primary care and other delivery systems to coordinate health and social services between settings of care; across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services); with external entities outside of the provider network; and with Community Supports and 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).

~~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.~~

Members are included in the planning and implementation of their care, with special emphasis on those members with mental health or substance abuse 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 adults) may be represented by parents, guardians, other family members or conservators, as appropriate, and in accordance with the member's wishes.

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. The PCP communicates

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to members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all care coordination provided to members, as appropriate.

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 covered services as well as services not covered.

The Alliance offers care coordination for the following services:

- ~~Appointments with specialists to meet time and distance and timely access standards~~
- ~~Services with out of network (OON) providers~~
- ~~Establishment of a member specific letter of agreement (LOA) with providers/specialists to meet time and distance and timely access standards~~
- ~~Behavioral health care~~
- ~~Alcohol and substance use disorder treatment services~~
- ~~Children with special health care needs~~
- ~~Early and Periodic Screening Diagnostic and Screening (EPSDT) service providers~~
- ~~California Children's Services (CCS)~~
- ~~Services for persons with developmental disabilities (Regional Center)~~
- ~~Early intervention service with the Early Start Program~~
- ~~Local Education Agency Services (LEA)~~
- ~~School linked CHDP services~~
- ~~HIV/AIDS waiver program~~
- ~~Dental services~~
- ~~Direct observed therapy (DOT) for treatment of Tuberculosis~~
- ~~Women, Infants, and Children (WIC) Supplemental Nutrition program~~
- ~~Excluded services requiring member disenrollment~~
- ~~Waiver Program~~
- ~~Transportation to appointments as needed for both In-Network and OON Providers to meet time and distance and timely access standards.~~
- ~~Private Duty Nursing and CBAS services~~

1. Coordination of Services with Out-of-Network Providers/ Letter of Agreement (LOA)

   ~~a~~a) The Alliance identifies members who may need or who are receiving services from out of plan providers and/or programs in order 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.~~.~~

      i. The LOA is offered at no less ~~that~~than the Medi-Cal Fee-For-Service rate, 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.~~membr.~~

      ~~ii.~~ Members are provided information on how to obtain out of network care in the Member's Handbook/Evidence of Coverage. When an authorization request for care by an out of network provider is approved, the member is informed in

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the Approval Letter. When a 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.

2. Coordination of Behavioral Health Care

~~2.~~

~~a~~a) Alameda Alliance for Health collaborates with its behavioral health specialists to identify opportunities to improve coordination of behavioral health care with general medical care that may include but is not limited to collaboration between organization and behavioral health specialists. The Alliance Policy *UM-012 Care Coordination - Behavioral Health* describes the process of care coordination for behavioral health services.

3. Coordination of Alcohol and Substance U~~u~~se Disorder Treatment Services

a) PCPs are responsible for identifying Members with active or potential substance ab~~ab~~use problems. Once Members are identified, PCPs are responsible for providing services for the substance ~~ab~~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 ~~ab~~use problem.

~~a~~b) PCPs are also responsible, with the assistance of the Alliance, for referring Members with substance abuse problems to an appropriate treatment practitioner or county department. The Alliance Policy *UM-013 Care Coordination – Substance Abuse* describes the process of care coordination for alcohol and substance use disorder treatment services.

4. Children with Special Health Care Needs

~~a~~a) The Alliance will assist with referrals/authorizations and care coordination to ensure that members receive the care appropriate for their medical, mental, or physical condition. The Alliance has individual policies describing the process of care coordination for children with special healthcare needs.

5. Early and Periodic Screening Diagnostic and Screening (EPSDT) service providers

a) The Alliance provides case management and care coordination to ensure that Members under the age of 21 can access Medically Necessary Early and Periodic Screening, Diagnostic Services, (EPSDT), also known as Medi-Cal for Kids & Teens services as determined by the Alliance Provider. For example, when school is not in session, the Alliance covers medically necessary EPSDT/Medi-Cal for Kids & Teens services that were being provided by the LEA program when school was in session. Where another entity, such as a Local Education Agency (LEA), RC, or local governmental health program, has overlapping responsibility for providing services to a m~~M~~ember under the age of 21, the Alliance does the following:~~:~~

i. ~~•~~ Assess what level of EPSDT/Medi-Cal for Kids & Teens medically necessary services the Member requires,

ii. ~~•~~ Determine what level of service (if any) is being provided by other

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entities, and

iii. ~~•~~ Coordinate the provision of services with the other entities to ensure that the Alliance and the other entities are not providing duplicative services, and that the Member is receiving all medically necessary EPSDT/Medi-Cal for Kids & Teens services in a timely manner.

6. California Children's Services (CCS)

~~5.~~

a) At AAH, CCS is a service carved out of the DHCS Contract for CCS-eligible conditions. If a Member of AAH is under the age of 21, has a CCS eligible condition, then the Member may obtain treatment related to the CCS-eligible condition from CCS if the Member enrolls in CCS. PCPs and specialists are responsible for early identification of Members that may have eligible CCS conditions. Medically necessary health care services will be administered throughout the referral process with the Alliance, regardless of whether or not the child is accepted into the CCS program (e.g., Early and Periodic Screening, Diagnosis and Treatment (EPSDT) ~~Supplemental~~ Services for Medi-Cal Members. also known as Medi-Cal for Kids and Teens.). The Alliance will consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU. The Alliance Policy *UM-008 Coordination of Care - California Children's Services* describes the process of care coordination with CCS.

~~a~~

7. Services for Persons with Developmental Disabilities (Regional Center)

~~6.~~

a) 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. 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. ~~Refer~~ The Alliance Policy ~~*to UM-020*~~*CM-029 Developmental Disabilities* ~~y~~ describes the process of care coordination with the Regional Center.

b) The Alliance is also responsible forauthorize a member's stay in an Intermediate Care Facility for the Developmentally Delayed (ICF/DD) homes following Alliance Policy- *LTC-002 LTC Authorization Criteria.*

~~a~~

~~7.~~ Early Intervention Services with the Early Start Program

8.

a) Primary Care Providers (PCPs) are responsible for assessing children's developmental status during Well Child exams, or at other medical encounters as appropriate. Children from birth to 36 months old identified at risk for, or suspected of having, a developmental disability or delay must be referred to the Regional Center of the East Bay (RCEB) for evaluation for the Early Start Program.

b) The Alliance will collaborate with Regional Center of the East Bay (RCEB) or local Early Start Program in determining the medically necessary diagnostic and preventive services and treatment plans for members participating in the Early Start program.

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The Alliance Policy ~~*UM*~~*CM-~~021~~ 030 Early Start* describes the process of care coordination with the Early Start Program.

~~a~~

9. Local Education Agency Services (LEA)

~~8.~~

a) 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. On an as needed basis, the Alliance will work with the PCP to coordinate care for a Member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the Individual Education plan developed by the LEA, with the PCP's participation. The Alliance Policy ~~*UM-027*~~*CM-032 Care Coordination - Local Education Agency Services* describes the process of care coordination with the LEA.

~~a~~

10. School Linked CHDP Services

~~9.~~

~~a~~a) All pediatric members will be assigned to a Primary Care Provider (PCP) who will be their "medical home." The Alliance will coordinate with school-linked CHDP Services in order to assure access for child and adolescent members to preventive and early intervention services. The Alliance Policy ~~*UM*~~*CM-0319 School linked CHDP Services* describes the process of care coordination with school linked CDHP services.

11. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver Program

~~10.~~

~~11.~~ Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered by Managed Medi-Cal. However, contracted PCPs and specialists (practitioners) have the responsibility to identify and refer Medi-Cal Managed Care Plan (MCP) members to an HIV/AIDS waiver program if they meet criteria. The Alliance Policy ~~*UM-017*~~*CM-033 Home and Community Based Services (Waiver Programs) - DDS* describes the process of care coordination for these services.

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12. Dental Services

~~12.~~

~~a~~a) Dental services are not covered by managed Medi-Cal. However, the Alliance will ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. The Alliance Policy *UM-024 Care Coordination - Dental Services* describes the process of care coordination for dental services.

13. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

~~13.~~

a) DOT is offered by the local health departments (LHDs) and is not covered by Managed Medi- Cal. PCPs will assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis therapy. The Alliance Policy *UM-023 Communicable Disease Reporting and Services* describes the process of care coordination for treatment of TB.

~~a~~

14. Women, Infants, and Children (WIC) -Supplemental Nutrition Program

~~14.~~

a) 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 for WIC services. The Alliance Policy *UM-030 Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)* describes the process of care coordination for these services.

~~a~~

~~15. Excluded Services Requiring Member Disenrollment~~

~~a. For services related to long-term care, the Alliance will initiate the disenrollment process. The Alliance Policy *UM-010 Coordination of Care - Long Term Care* describes the process of care coordination for patients admitted to long- term care.~~

15. Waiver Programs

~~16.~~

a) Members who may qualify for one of the Waiver Programs will be identified by their PCP, with Utilization Management (UM) Department support, based on their diagnosis and need for a specific level of care. The Alliance Policy *~~UM~~CM-~~017~~ 033 Home and Community Based Services (Waiver Programs)-DDS* describes the process of care coordination with these waiver programs.

~~a~~

16. Transportation Services

~~17.~~

~~a~~a) The Alliance will assist members to obtain transportation to services as needed to assure that members can obtain care within the time and distance and timely access standards.

17. Private Duty Nursing and Community Based Adult Services (CBAS) ~~services~~

~~18.~~

a) Private Duty Nursing and 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 *CM-019 Private Duty Nursing Case Management for Members under the age of 21* and CBAS

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policies.

D. Authorization of Services

Services should be medically necessary and recommended by the PCP or the Specialty Care Provider (SCP). Members have a 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 (either the health plan or the delegated Medical Group/IPA) based on medical~~ly~~ necessity.

PROCEDURE

I. Coordination Process

~~A.~~ The patient'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.

A.

~~1.~~ Includes any documentation of care/services provided regarding mental health ~~a~~ and/or substance abuse, providing the member has authorized the mental health/substance abuse provider to disclose that information.

1.

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2. Documentation of referral/receipt of long-term supports and services.

3. Documentation may be direct or consist of summary, consultation letters, discharge notes and progress notes submitted by outside providers.

3.4. 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 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.).

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 ~~xyz~~X drug), etc.).

D. Urgent and Emergency Care Services.

~~1. When urgent services are not available with the member's PCP, the PCP arranges/refers the member to an appropriate source for care within the network.~~

2.1. 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.

3.2. Emergency services are available through the Emergency Medical Services system (911) or through an emergency room (see Emergency Services Policy) 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.

1. 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.

2. Each practitioner participating in the member's care will provide information on

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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.

~~2.~~

3. This information should include:

~~i)~~a) The member's condition

~~ii)~~b) Any proposed treatments or procedures and alternatives

~~iii)~~c) The benefits, drawbacks, and likelihood of success of each option

~~iv)~~d) The possible consequences of refusal or non-compliance with a recommended course of care.

~~F.~~ Members who are unable or unwilling to participate in their own care will be assessed through Care Coordination/Utilization Management, appropriately counseled, and given all

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of their health care options in order to be ~~channeled~~ referred into the most appropriate long-term services and supports~~, and services~~ and other community agencies.

F.

G. The areas where members need to be able to fully participate in their care include, but are not limited to, the following:

~~G.~~

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

H. The Alliance implements information-sharing processes and referral support infrastructure. All member information will be kept confidential. The Alliance:

1. Ensures that providers furnishing services to members maintain and share, as appropriate, members' medical records in accordance with professional standards and state and federal law.

~~H~~2. Facilitates exchange of necessary member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable.

I. The Alliance maintains processes to ensure no duplication of services occurs.

J. Care coordination consists of health care professionals with appropriate experience and/or special education related to the targeted population.

~~I~~

1. Coordinators serve as a resource both internally and throughout the provider network.

2. Education on health promotion and preventive services is prepared for distribution to members and their providers on an ongoing basis.

~~2.~~

3. Disease management programs integrate the full range of services available from the plan and within the community.

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K. Whenever possible, services are coordinated through both contracted and non-contract providers in the service area to ensure continuity of care and integration of services with long-term ~~supports and~~ services and supports, and other community and social service programs.

L. See Attachments for Care Coordination and OON/LOA Workflows.

~~The Alliance provides resources to network providers for referrals in order to ensure that BPHM is provided to all members. The Alliance:~~

- ~~Maintains a system to electronically track and monitor provider referrals not requiring Prior Authorization, including referrals for care management services, and the outcomes of referrals.~~
- ~~Provides access to a current and continuously updated community resource directory to providers.~~
- ~~Provides a toll-free telephone number for providers to obtain assistance in arranging referrals.~~
  - ~~Telephone referral assistance addresses referrals for mental health and SUD treatment, developmental services, dementia, palliative care, dental, personal care services, and LTSS~~
  - ~~The Alliance communicates the availability of telephone referral assistance by providing the toll-free number on the homepage of the website and in materials supplied to providers, including the Provider Manual.~~

M. For the following entities, the Alliance will establish a closed loop referral process.

1. CalFresh
2. California Work Opportunity and Responsibility to Kids (CalWORKs)
3. CCS
4. CHW services, and services provided by peer counselors, and local community organizations.
5. Community Supports
6. Dental providers
7. Developmental Services (DD)
8. ECM Community Supports
9. IHSS & HCBS: County and social services agencies and waiver agencies for IHSS and other home and community-based services (HCBS)

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10. Specialty mental health services, (in the Alliance network, Alameda County Behavioral Health, or Medi-Cal FFS delivery system) to ensure the members receive timely mental health services, without delay regardless of where they initially seek care, in accordance with "No Wrong Door" policy

11. SUD: Appropriate delivery system for SUD services

12. Supplemental Security Income (SSI)

13. Women, Infants and Children (WIC)

14. All other programs requiring Memorandums of Understanding (MOUs)

N. The Alliance will coordinate warm handoffs with local health departments and other public benefit programs, starting January 2025.

O. The Alliance enters into MOUs with various programs to ensure coordination of care in alignment with the 2024 DHCS contract requirements.

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 Alliance Policy *OI-111 Delegation Management and Oversight*~~CMP-019 for monitoring of delegation oversight~~.

DEFINITIONS

BPHM – Basic Population Health Management
~~**CalWorks**~~**CalWORKs** - California Work Opportunity and Responsibility to Kids
CBAS – Community-Based Adult Services
CCS – California Children's Services
CHDP – Child Health and Disability Prevention Program
CHW – Community Health Worker
DDS – Department of Developmental Services
ECM – Enhanced Care Management
HCBS – Home and Community Based Services
IHSS – In-Home Supportive Services
LEA – Local Education Agencies
LOA – Letter of agreement

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LTSS – Long-term services and supports
MOU – Memorandum of Understanding
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)
~~None.~~

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CM-029 Developmental Disabilities
CM-030 Early Start
CM-031 School Linked CHDP Services
CM-032 Care Coordination - Local Education Agency Services
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-008 Coordination of Care - California Children's Services (CCS)
UM-010 Coordination of Care - Long Term Care
UM-012 Care Coordination - Behavioral Health
UM-013 Coordination of Care - Substance Abuse
UM-016 Transportation Guidelines
UM-023 Communicable Disease Reporting and Services
UM-024 Care Coordination – Dental Services
UM-030 Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)

~~QI-111 Delegation Management and Oversight Management~~
~~QI-135 Early and Periodic Screening and Diagnostic (EPSDT) Services~~
~~CRE-009 Ongoing Monitoring of Practitioners PCP, Specialist and Delegated Provider Contracts Provider Manual Sections 5, 6, 8 and 11~~
~~UM-008 Coordination of Care- California Children's Services (CCS)~~
~~UM-010 Coordination of Care - Long Term Care~~
~~UM-012 Care Coordination-Behavioral Health~~
~~UM-013 Coordination of Care – Substance Abuse~~
~~UM-016 Transportation Guidelines~~
~~UM-018 Targeted Case Management (TCM) and Early and Periodic Screening and Diagnostic Services (EPSDT)~~
~~UM-019CM-031 School Linked CHDP Services~~
~~UM-020CM-029 Developmental Disabilities~~

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~~UM-021~~CM-030 ~~Early Start~~
~~UM-027~~CM-032 ~~Care Coordination – Local Education Agency Services~~

RELATED WORFLOW DOCUMENTS OR OTHER ATTACHMENTS

UM-002 Attachment 1: Care Coordination Workflow
UM-002 Attachment 2: Case Management Workflow for OON -Providers/Service
UM-002 Attachment 3: UM OON LOA Workflow

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REVISION HISTORY

1/1/2008, 7/28/2008, 10/28/2009, 9/07/2012, 04/17/2013, 04/07/2014, 01/01/2016, 12/15/2016, 04/16/2019, 5/21/2020, 3/22/2022, 02/21/2023, 1/24/24

REFERENCES

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1. DHCS Contract, Exhibit A, Attachment 11, Provisions 1 and 2
2. 42 CFR Section 422.112(b)(3)
3. 42 CFR Section 438.208
4. 45 CFR Sections 160 and 164(a) and (e)
5. DHCS 2024 MCP Contract

~~1. DHCS Contract, Exhibit A, Attachment 11, Provisions 1 and 2~~

~~2. Title 42, CFR, Section 422.112(b)(3)~~

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.

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-002
Policy Name	Coordination of Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Senior Director, Health Care Services
Lines of Business	All
Effective Date	11/21/2006
Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (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 medical case management include care coordination for medically necessary services provided to members within and outside of the Alliance's provider network, based on the individual member's needs. The Alliance is the primary provider of such medical services except for those services that have been expressly carved-out.

A. Delivery of Primary Care

The Alliance ensures that members have an ongoing 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. The Alliance 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.

B. Primary Care Provider (PCP) Role

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. The Alliance ensures that each member is engaged with their assigned PCP, who plays a key role in coordination and continuity of care. The PCP has the responsibility and authority to direct and coordinate the members' services. These responsibilities include: 1) Act as the primary case manager for all assigned members, 2) Assess the acute, chronic, and preventive needs of each member, 3) Ensure members receive all needed preventive services, and 4) Provide members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes.

C. Coordination of Services

The Alliance partners with primary care and other delivery systems to coordinate health and social services between settings of care; across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services); with external entities outside of the provider network; and with Community Supports and other community-based resources, even if they are not covered services, to guarantee members' needs are addressed and to mitigate impacts of SDOH.

Members are included in the planning and implementation of their care, with special emphasis on those members with mental health or substance abuse 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 adults) may be represented by parents, guardians, other family members or conservators, as appropriate, and in accordance with the member's wishes.

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. 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.

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 covered services as well as services not covered.

The Alliance offers care coordination for the following services:

- Appointments with specialists to meet time and distance and timely access standards
- Services with out of network (OON) providers
- Establishment of a member specific letter of agreement (LOA) with providers/specialists to meet time and distance and timely access standards
- Behavioral health care

- Alcohol and substance use disorder treatment services
- Children with special health care needs
- Early and Periodic Screening Diagnostic and Screening (EPSDT) service providers
- California Children's Services (CCS)
- Services for persons with developmental disabilities (Regional Center)
- Early intervention service with the Early Start Program
- Local Education Agency Services (LEA)
- School linked CHDP services
- HIV/AIDS waiver program
- Dental services
- Direct observed therapy (DOT) for treatment of Tuberculosis
- Women, Infants, and Children (WIC) Supplemental Nutrition program
- Excluded services requiring member disenrollment
- Waiver Program
- Transportation to appointments as needed for both In-Network and OON Providers to meet time and distance and timely access standards.
- Private Duty Nursing and CBAS services

1. Coordination of Services with Out-of-Network Providers

The Alliance identifies members who may need or who are receiving services from out of plan providers and/or programs in order 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.

- The LOA is offered at no less than the Medi-Cal Fee-For-Service rate, is agreed upon by the Alliance and the provider, and is made within the most recent year.
- Members are provided information on how to obtain out of network care in the Member's Handbook/Evidence of Coverage. When an authorization request for care by an out of network provider is approved, the member is informed in the Approval Letter. When a 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.

2. Coordination of Behavioral Health Care

Alameda Alliance for Health collaborates with its behavioral health

specialists to identify opportunities to improve coordination of behavioral health care with general medical care that may include but is not limited to collaboration between organization and behavioral health specialists. The Alliance Policy *UM-012 Care Coordination - Behavioral Health* describes the process of care coordination for behavioral health services.

3. Coordination of Alcohol and Substance use Disorder Treatment Services

   PCPs are responsible for identifying Members with active or potential substance abuse problems. Once Members are identified, PCPs are responsible for providing services for the substance abuse problem within their scope of practice (counseling and/or treatment) and for performing the appropriate medical work-up given the nature of the substance abuse problem. PCPs are also responsible, with the assistance of the Alliance, for referring Members with substance abuse problems to an appropriate treatment practitioner or county department. The Alliance Policy *UM-013 Care Coordination - Substance Abuse* describes the process of care coordination for alcohol and substance use disorder treatment services.

4. Children with Special Health Care Needs

   The Alliance will assist with referrals/authorizations and care coordination to ensure that members receive the care appropriate for their medical, mental, or physical condition. The Alliance has individual policies describing the process of care coordination for children with special healthcare needs.

5. Early and Periodic Screening Diagnostic and Screening (EPSDT) service providers

   The Alliance provides case management and care coordination to ensure that Members under the age of 21 can access Medically Necessary Early and Periodic Screening, Diagnostic Services, (EPSDT), also known as Medi-Cal for Kids & Teens services as determined by the Alliance Provider. For example, when school is not in session, the Alliance covers medically necessary EPSDT/Medi-Cal for Kids & Teens services that were being provided by the LEA program when school was in session. Where another entity, such as a Local Education Agency (LEA), RC, or local governmental health program, has overlapping responsibility for providing services to a Member under the age of 21, the Alliance does the following:

   - Assess what level of EPSDT/Medi-Cal for Kids & Teens medically necessary services the Member requires,
   - Determine what level of service (if any) is being provided by other entities, and
   - Coordinate the provision of services with the other entities to ensure that the Alliance and the other entities are not providing duplicative services, and that the Member is receiving all medically necessary EPSDT/Medi-Cal for Kids & Teens services in a timely manner.

6. California Children's Services (CCS)

   At AAH, CCS is a service carved out of the DHCS Contract for CCS-eligible

conditions. If a Member of AAH is under the age of 21 has a CCS eligible condition, then the Member may obtain treatment related to the CCS-eligible condition from CCS if the Member enrolls in CCS. PCPs and specialists are responsible for early identification of Members that may have eligible CCS conditions. Medically necessary health care services will be administered throughout the referral process with the Alliance, regardless of whether or not the child is accepted into the CCS program (e.g., Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services for Medi-Cal Members. also known as Medi-Cal for Kids and Teens.). The Alliance will consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU. The Alliance Policy *UM-008 Coordination of Care - California Children's Services* describes the process of care coordination with CCS.

7. Services for Persons with Developmental Disabilities

   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. 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. The Alliance Policy *CM-029 Developmental Disabilities* describes the process of care coordination with the Regional Center.

8. Early Intervention Services

   Primary Care Providers (PCPs) are responsible for assessing children's developmental status during Well Child exams, or at other medical encounters as appropriate. Children from birth to 36 months old identified at risk for, or suspected of having, a developmental disability or delay must be referred to the Regional Center of the East Bay (RCEB) for evaluation for the Early Start Program. The Alliance will collaborate with Regional Center of the East Bay (RCEB) or local Early Start Program in determining the medically necessary diagnostic and preventive services and treatment plans for members participating in the Early Start program. The Alliance Policy *CM-030 Early Start* describes the process of care coordination with the Early Start Program.

9. Local Education Agency Services

   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. On an as needed basis, the Alliance will work with the PCP to coordinate care for a Member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the Individual Education plan developed by the LEA, with the PCP's participation. The Alliance Policy *CM-032 Care Coordination - Local Education Agency Services* describes the process of care coordination with the LEA.

10. School Linked CHDP Services

All pediatric members will be assigned to a Primary Care Provider (PCP) who will be their "medical home." The Alliance will coordinate with school-linked CHDP Services in order to assure access for child and adolescent members to preventive and early intervention services. The Alliance Policy *CM-031 School linked CHDP Services* describes the process of care coordination with school linked CDHP services.

11. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)

    Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered by Managed Medi-Cal. However, contracted PCPs and specialists (practitioners) have the responsibility to identify and refer Medi-Cal Managed Care Plan (MCP) members to an HIV/AIDS waiver program if they meet criteria. The Alliance Policy *CM-033 Home and Community Based Services (Waiver Programs) - DDS* describes the process of care coordination for these services.

12. Dental Services

    Dental services are not covered by managed Medi-Cal. However, the Alliance will ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. The Alliance Policy *UM-024 Care Coordination - Dental Services* describes the process of care coordination for dental services.

13. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

    DOT is offered by the local health departments (LHDs) and is not covered by Managed Medi- Cal. PCPs will assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis therapy. The Alliance Policy *UM-023 Communicable Disease Reporting and Services* describes the process of care coordination for treatment of TB.

14. Women, Infants, and Children Supplemental Nutrition Program

    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 for WIC services. The Alliance Policy *UM-030 Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)* describes the process of care coordination for these services.

15. Excluded Services Requiring Member Disenrollment

    For services related to long-term care, the Alliance will initiate the disenrollment process. The Alliance Policy *UM-010 Coordination of Care - Long Term Care* describes the process of care coordination for patients admitted to long-term care.

16. Waiver Program

    Members who may qualify for one of the Waiver Programs will be identified by

their PCP, with Utilization Management (UM) Department support, based on their diagnosis and need for a specific level of care. The Alliance Policy *CM-033 Home and Community Based Services (Waiver Programs)-DDS* describes the process of care coordination with these waiver programs.

17. Transportation Services

    The Alliance will assist members to obtain transportation to services as needed to assure that members can obtain care within the time and distance and timely access standards.

18. Private Duty Nursing and CBAS services

    Private Duty Nursing and 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 *CM-019 Private Duty Nursing Case Management for Members under the age of 21* and CBAS policies.

D. Authorization of Services

Services should be medically necessary and recommended by the PCP or the Specialty Care Provider (SCP). Members have a 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 (either the health plan or the delegated Medical Group/IPA) based on medical necessity.

PROCEDURE

I. Coordination Process

1. The patient'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.
   a) Includes any documentation of care/services provided regarding mental health and/or substance abuse, providing the member has authorized the mental health/substance abuse provider to disclose that information.
   b) Documentation of referral/receipt of long-term supports and services.
   c) Documentation may be direct or consist of summary, consultation letters, discharge notes and progress notes submitted by outside providers.
   d) When a member chooses a new PCP within the same network, the medical records are transferred to the new provider in a timely manner.

2. Continuity of care issues may include but are not limited to:
   a) Ongoing DME in use in the member's home by the member (i.e., wheelchair, hospital bed, oxygen, etc.);
   b) Open authorizations to specialty or diagnostic testing services (i.e., MRI, PT, Specialty consultation/follow-up visits, etc.);

c) 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.;
d) Disease management goals, interventions, and outcomes.
e) Pharmacy utilization issues (i.e., non-formulary medications, poly-pharmacy issues; contraindicated medications, etc.);
f) Other issues (i.e., member out of area 3 months out of the year, member resides in a custodial care facility, etc.).

3. 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.).

4. Urgent and Emergency Care Services.
a) When urgent services are not available with the member's PCP, the PCP arranges/refers the member to an appropriate source for care within the network.
b) 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.
c) Emergency services are available through the Emergency Medical Services system (911) or through an emergency room (see Emergency Services Policy) either within or outside the service area, and without prior authorization.

5. 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.
a) 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.
b) 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.
c) This information should include:
i) The member's condition
ii) Any proposed treatments or procedures and alternatives
iii) The benefits, drawbacks, and likelihood of success of each option
iv) The possible consequences of refusal or non-compliance with a recommended course of care.

6. Members who are unable or unwilling to participate in their own care will be assessed through Care Coordination/Utilization Management, appropriately counseled, and given all of their health care options in order to be referred into the most appropriate long-term services and supports, and other community agencies.

7. The areas where members need to be able to fully participate in their care include, but are not limited to, the following:
a) Self-Care

b) Medication Management
c) Disease Management
d) Use of medical equipment
e) Potential complications and when those should be reported to providers
f) Scheduling of follow-up services
g) Member education, especially as it relates to discharge planning

8. The Alliance implements information-sharing processes and referral support infrastructure. All member information will be kept confidential. The Alliance:
   a) Ensures that providers furnishing services to members maintain and share, as appropriate, members' medical records in accordance with professional standards and state and federal law.
   b) Facilitates exchange of necessary member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable.

9. The Alliance maintains processes to ensure no duplication of services occurs.

10. Care coordination consists of health care professionals with appropriate experience and/or special education related to the targeted population.
    a) Coordinators serve as a resource both internally and throughout the provider network.
    b) Education on health promotion and preventive services is prepared for distribution to members and their providers on an ongoing basis.
    c) Disease management programs integrate the full range of services available from the plan and within the community.

Whenever possible, services are coordinated through both contracted and non-contract providers in the service area to ensure continuity of care and integration of services with long-term services and supports, and other community and social service programs.

11. See Attachments for Care Coordination and OON/LOA Workflows.

12. For the following entities, the Alliance will establish a closed loop referral process.
    a) CalFresh
    b) California Work Opportunity and Responsibility to Kids (CalWORKs)
    c) CCS
    d) CHW services, and services provided by peer counselors, and local community organizations.
    e) Community Supports
    f) Dental providers
    g) Developmental Services (DD)
    h) ECM Community Supports
    i) IHSS & HCBS: County and social services agencies and waiver agencies for IHSS and other home and community-based services (HCBS)
    j) Specialty mental health services, (in the Alliance network, Alameda County

Behavioral Health, or Medi-Cal FFS delivery system) to ensure the members receive timely mental health services, without delay regardless of where they initially seek care, in accordance with "No Wrong Door" policy

k) SUD: Appropriate delivery system for SUD services
l) Supplemental Security Income (SSI)
m) Women, Infants and Children (WIC)
n) All other programs requiring Memorandums of Understanding (MOUs)

13. The Alliance will coordinate warm handoffs with local health departments and other public benefit programs, starting January 2025.

14. The Alliance enters into MOUs with various programs to ensure coordination of care in alignment with the 2024 DHCS contract requirements.

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 Alliance Policy *QI-111 Delegation Management and Oversight*.

DEFINITIONS

BPHM – Basic Population Health Management
CalWORKs - California Work Opportunity and Responsibility to Kids
CBAS – Community-Based Adult Services
CCS – California Children's Services
CHDP – Child Health and Disability Prevention Program
CHW – Community Health Worker
DDS – Department of Developmental Services
ECM – Enhanced Care Management
HCBS – Home and Community Based Services
IHSS – In-Home Supportive Services
LEA – Local Education Agencies
LOA – Letter of agreement
LTSS – Long-term services and supports
MOU – Memorandum of Understanding
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

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CM-029 Developmental Disabilities
CM-030 Early Start
CM-031 School Linked CHDP Services
CM-032 Care Coordination - Local Education Agency Services
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-008 Coordination of Care - California Children's Services (CCS)
UM-010 Coordination of Care - Long Term Care
UM-012 Care Coordination - Behavioral Health
UM-013 Coordination of Care - Substance Abuse
UM-016 Transportation Guidelines
UM-023 Communicable Disease Reporting and Services
UM-024 Care Coordination – Dental Services
UM-030 Referrals to the Supplemental Food Program for Women, Infants and Children (WIC)

RELATED WORFLOW DOCUMENTS OR OTHER ATTACHMENTS

UM-002 Attachment 1: Care Coordination Workflow
UM-002 Attachment 2: Case Management Workflow for OON Providers/Service
UM-002 Attachment 3: UM OON LOA Workflow

REVISION HISTORY

1/1/2008, 7/28/2008, 10/28/2009, 9/07/2012, 04/17/2013, 04/07/2014, 01/01/2016, 12/15/2016, 04/16/2019, 5/21/2020, 3/22/2022, 02/21/2023

REFERENCES

1. DHCS Contract, Exhibit A, Attachment 11, Provisions 1 and 2
2. 42 CFR Section 422.112(b)(3)
3. 42 CFR Section 438.208
4. 45 CFR Sections 160 and 164(a) and (e)
5. DHCS 2024 MCP Contract

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	LTC-005
Policy Name	Coordination of Care – Long Term Care
Department Name	Medical Services
Department Officer	Long Term Services and Supports Director
Department Owner	Medical Director
Lines of Business	All
Effective Date	11/21/2006
Approval Date	TBD

POLICY STATEMENT

A. Long Term Care (LTC) facilities include Nursing Facilities, Adult Sub Acute, Pediatric Sub Acute and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) .

B. Alameda Alliance for Health (Alliance) is financially responsible for Medi-Cal Members requiring Long Term Care (LTC) facility admission.

C. The Alliance is responsible for identifying Members who require admission to LTC facilities, either after an acute inpatient admission or skilled nursing facility admission, or as direct admits from the community.

D. The Alliance is responsible for providing all necessary care management (CM) and care coordination for Members in LTC facilities, including estimating the length of stay.

PROCEDURE

A. Alameda Alliance for Health has the responsibility of determining the appropriate level of care and facility placement of Members.

B. Criteria for admission of Medi-Cal Members to various levels of LTC facilities are described in the following sections of Title 22 California Code of Regulations:

   a. Skilled Nursing Facility - Section 51124

   b. Sub-acute Level of Care - Section 51124.5

   c. Pediatric Sub-acute Care Services - Section 51124.6

   d. Intermediate Care Services - Section 51120.5

   5. Other sections – 51335, 51335.5, 51335.6, 51334, 51003(e)

C. Members can be admitted to LTC facilities from acute inpatient settings or as direct admits from the community. In either case, the treating PCP or specialist must notify Alameda Alliance for Health of the need for admission. Alameda Alliance for Health is responsible for coordinating all aspects of the admission including:

   a. Coordinating with the assigned facility to determine the appropriate level of care for the Member;

   b. Arranging, in consultation with the assigned facility, any necessary transport services; utilizing Modivcare

   c. Arranging for any necessary transfer of medical information.

D. The Alliance is financially responsible for Medi-Cal Members placed in a LTC facility

E. The Alliance is responsible for the coordination of the Member's medical needs while in the LTC Facility.

F. The Alliance is responsible for issuing a Last Covered Day letter to facilities and Members when they no longer meet Long Term Care criteria.

G. Alameda Alliance for Health will facilitate all discharge arrangements for the continued medical management of the Member after discharge back into the community including coordinating necessary authorizations for services and referral to appropriate level of care management.

   a. Transitional Care Services (TCS) will be provided to members who will have the ability to discharge from the LTC facility.

   b. TCS includes:

      a. Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility

      b. Discharge Risk Assessment

      c. Discharge Planning document.

         i. A full description of the Alliance TCS program is found in *CM- 034 Transition of Care Policy.*

H. For Medi-Cal Members, AAH is responsible for assessing whether a Member may be eligible for the Home Based Community Alternatives (HCBA) Waiver or Enhanced Care Management (ECM) in consultation with the Member, Member's family, or Facility as necessary.

   a. If a Member is determined to be a potential candidate, the Alliance facilitates the application for the waiver for the HCBA program or the referral into the ECM program.

   b. Coordination of Care/Utilization Management department, the PCP and/or treating physician are responsible for providing and coordinating all necessary care throughout the application/ referral process.

I. When the Member no longer meets criteria for LTC care, the Alliance collaborate with the facility to ensure the Member's discharge back into the community or an appropriate lower level of care.

   a. This includes notifying the Member and his or her family or guardian of the anticipated discharge

   b. Assuring all necessary services are authorized and referrals made to appropriate care management programs

c. Assuring that continuity of care is not interrupted

d. Completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Member.

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

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CM- 034 Transition of Care Policy.
CMP-019 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 8/29/2012, 7/12/2013, 1/2/2014, 01/10/2016, 04/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 1/23/24

REFERENCES

1. DHCS Contract, Exhibit A, Attachment 3, Section 18. A.
2. Title 22, CCR, Sections 51120, 51124, 51003, 51335
3. APL 23-004 Skilled Nursing Facilities- LTC Benefit Standardization and Transition of Members to Managed Care.
4. APL 23-023 Intermediate Care Facilities for Individuals for Developmentally Disabled- LTC Benefit Standardization and Transition of Members to Managed Care.
5. APL 23-027- SubAcute Care Facilities- LTC 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 Healthcare Quality Committee annually.

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Service you can trust.

POLICY AND PROCEDURE

Policy Number	~~UM-010~~LTC-005
Policy Name	Coordination of Care – Long Term Care
Department Name	Medical Services
Department Officer	~~Senior Director, Health Care Services~~Long Term Services and Supports Director
Department Owner	Medical Director
Lines of Business	All
Effective Date	11/21/2006
Approval Date	TBD~~02/21/2023~~

POLICY STATEMENT

A. Long Term Care (LTC) facilities include ~~skilled~~ N~~n~~ursing Facilities, A~~a~~dult S~~s~~ub A~~-a~~cute, P~~p~~ediatric S~~s~~ub A~~-a~~cute and ~~other i~~Intermediate C~~c~~are Facilities for the Developmentally Disabled ~~units~~(ICF/DD) .

B. Alameda Alliance for Health (Alliance) is financially responsible for Medi-Cal Members requiring Long Term Care (LTC) facility admission.

~~C.~~ The Alliance is responsible for identifying Members who require admission to LTC facilities, either after an acute inpatient admission ~~, transitioning from a sub-acute~~ or skilled nursing facility admission, or as direct admits from the community.

C.

The Alliance is responsible for providing all necessary ca~~s~~re management (CM) and care coordination for Members in LTC facilities, including estimating the length of stay.

D.

~~D. An admission to a nursing facility for hospice services is not considered long-term care and does not require disenrollment, regardless of the length of stay. The following settings are considered appropriate for post-acute care admission into Hospice:~~

- ~~The member's home;~~
- ~~A distinct part of a hospital psychiatric or rehabilitation unit;~~
- ~~A home-based community setting~~

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PROCEDURE

A. Alameda Alliance for Health has the responsibility of determining the appropriate level of care and facility placement of Members.

B. Criteria for admission of Medi-Cal Members to various levels of LTC facilities are described in the following sections of Title 22 California Code of Regulations:

~~1.~~a. Skilled Nursing Facility - Section 51124

~~2.~~b. Sub-acute Level of Care - Section 51124.5

~~3.~~c. Pediatric Sub-acute Care Services - Section 51124.6

~~4.~~d. Intermediate Care Services - Section 51120.5

5. Other sections – 51335, 51335.5, 51335.6, 51334, 51003(e)

C. Members can be admitted to LTC facilities from acute inpatient settings or as direct admits from the community. In either case, the treating PCP or specialist must notify Alameda Alliance for Health of the need for admission. Alameda Alliance for Health is responsible for coordinating all aspects of the admission including:

~~1.~~a. Coordinating with the assigned facility~~Hospital~~ to determine the appropriate level of care ~~contracted facility~~ for the Member;

~~2.~~b. Arranging, in consultation with the assigned facility~~Hospital~~, any necessary transport services; utilizing Modivcare

~~3. Arranging for physician coverage at the facility as needed; and~~

~~a.~~ Arranging for any necessary transfer of medical information.

c.

D. The Alliance is financially responsible for Medi-Cal Members placed in a LTC facility

~~B.~~ The Alliance is responsible for the coordination of the Member's medical needs while in the LTC Facility~~inpatient~~. ~~Alameda Alliance for Health will establish a length of stay estimate for the Member as soon as possible after admission.~~

E.

~~C.~~ The Alliance is responsible for issuing a Last Covered Day letter to facilities and Members when they no longer meet Long Term Care~~skilled nursing, rehabilitative care or custodial care~~ criteria.

F.

~~D.~~ Alameda Alliance for Health will facilitate all discharge arrangements for the continued medical management of the Member after discharge back into the community including coordinating necessary authorizations for services and referral to appropriate level of care management.

G.

a. Transitional Care Services (TCS) will be provided to members who will have the ability to discharge from the LTC facility.

~~E.~~TCS includes:

b.

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a. Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility ~~to facilitate the participation of the Care Manager with the discharge planning and follow up.~~

b. Discharge Risk Assessment

c. Discharge Planning document.

i. A full description of the Alliance TCS program is found in *CM- ~~CM~~-034 Transition of Care P~~p~~olicy.*

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~~E.~~H. For Medi-Cal Members, ~~Coordination of Care/Utilization Management~~AAH is responsible for assessing whether a Member may be eligible for the Home Based Community Alternatives (HCBA) Waiver~~/Nursing Facility (NF)Waiver Program,~~ or Enhanced Care Management (ECM) in consultation with the Member, Member's family, or Facility as necessary.

a. If a Member is determined to be a potential candidate, the Alliance facilitates the application for the waiver for the HCBA program or the referral into the ECM program. ~~.~~

b. Coordination of Care/Utilization Management department, the PCP and/or treating physician are responsible for providing and coordinating all necessary care throughout the ~~HCBA~~ application/ referral process. ~~and up to disenrollment to the FFS Program.~~

~~c. If the Member is not accepted into the HCBA/NF Waiver Program, Alameda Alliance for Health and the PCP remain responsible for all necessary care and Case Management.~~

~~F.~~I. When the Member no longer meets criteria for LTC ~~skilled nursing, rehabilitative care or custodial~~ care, the Alliance collaborate with the facility to ~~shall~~ ensure the Member's ~~orderly and ned dis~~discharge back into the community or an appropriate lower level of care.

a. This includes notifying the Member and his or her family or guardian of the anticipated discharge

b. Assuring all necessary services are authorized and referrals made to appropriate care management programs

c. Assuring that continuity of care is not interrupted

d. Completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Member.

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 ~~9 for monitoring of~~ D~~d~~elegation O~~o~~versight.*

DEFINITIONS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CM- 034 Transition of Care Policy.
CMP-019 Delegation Oversight

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

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1/1/2008, 10/28/2009, 8/29/2012, 7/12/2013, 1/2/2014, 01/10/2016, 04/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 1/23/24

REFERENCES

1. DHCS Contract, Exhibit A, Attachment 3~~11~~, Section 18. A.
2. Title 22, CCR, Sections ~~51118,~~ 51120, ~~51121,~~ 51124, ~~51334,~~ 51003, 51335
~~3. APL 22-018 Skilled Nursing Facilities – LTC Benefit Standardization and Transition of Members to Managed Care.~~3. APL 23-004 Skilled Nursing Facilities- LTC Benefit Standardization and Transition of Members to Managed Care.
4. APL 23-023 Intermediate Care Facilities for Individuals for Developmentally Disabled- LTC Benefit Standardization and Transition of Members to Managed Care.
5. APL 23-027- SubAcute Care Facilities- LTC 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 Healthcare Quality Committee annually.

POLICY AND PROCEDURE

Policy Number	BH-005~~UM-012~~
Policy Name	Care Coordination – Behavioral Health
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Senior Director, Behavioral Health Care Services
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

A. Alameda Alliance for Health (the Alliance) Primary Care Providers (PCPs) are required to provide behavioral health and/or substance abuse services, including diagnosis and treatment, within their scope of practice.

B. PCPs are required to provide mental health (MH) and substance use disorder (SUD) screening for their assigned members.

1. If the PCP cannot perform the mental health/SUD assessment, they are required to refer the member to an appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, whether to the Alliance's Behavioral Health department, or to the Alameda County Behavioral Health services.

2. Members with positive screening results may be further assessed by the PCP or by referral to the appropriate mental health/SUD delivery system.

C. PCPs treating Members with behavioral health SUD needs beyond the PCP's scope of practice, in terms of diagnosis or treatment, must refer the member to the appropriate Mental Health/SUD Provider.

1. Medi-Cal – The Alliance's Behavioral Health department which will in turn coordinate with the Alameda County Behavioral Health (ACBH

2. All other Lines of Business – The Alliance's Behavioral Health department.

D. At any time, members can choose to seek and obtain a mental health/SUD assessment from a licensed mental health provider within the AAH network.

E. AAH furnishes all services defined as appropriate and medically necessary under Medicaid 42 USC Section 1396d(a) necessary to correct or ameliorate health conditions, including behavioral health/SUD conditions, discovered by a screening service, regardless of whether those services are covered in the California Medi-Cal plan.

F. Behavioral Health/SUD services need not be curative or restorative to ameliorate a behavioral health condition, consistent with federal guidance from Centers for Medicare and Medicaid Services (CMS.)

G. Behavioral/SUD Health services that sustain, support, improve or make more tolerable a behavioral health/SUD condition are considered to ameliorate the condition, and are thus medically necessary. They are also covered as Early and Periodic Screening, Diagnostic and Treatment, (EPSDT) services.

H. For members who are 21 years of age or older, services are considered medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

I. AAH arranges for the provision of Non-Specialty Mental Health Services (NSMHS) and SUD services for all members, including the following populations:

1. Members who are 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM);

2. Members who are under the age of 21, to the extent they are eligible for services through the Medicaid EPSDT benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;

3. Members who are under the age of 21, with specified risk factors or with persistent mental health symptoms in absence of a mental health disorder, are subject to psychotherapy, and

4. Members of any age with potential mental health disorders not yet diagnosed.

J. AAH covers up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth.

K. AAH arranges for the provision of medically necessary SMHS for members who meet access criteria for SMHS as described in the Behavioral Health Information Notice (BHIN) 21-073

L. AAH arranges for the provision of the following non-specialty mental health services (NSMHS):

1. Mental health evaluation and treatment, including individual, group and family psychotherapy;
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for purposes of monitoring drug therapy;
4. Psychiatric consultation;
5. Outpatient laboratory, drugs, supplies, and supplements.

M. Services are defined as “medically necessary” or a “medical necessity” in accordance with the California Welfare and Institutions Code (W&I) sections 14059.5 and 14184.402, for individuals under 21, a service is “medically necessary” or a ‘medical necessity” when the service meets the standards set forth in Section 1396d©(5) of Title 42 of the United States Code (U.S.C.) This includes NSMHS and SUD services and are covered by AAH as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

AAH covers and pays for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations. This includes facility and professional services and facility charges claimed by emergency departments, all professional physical, mental, and substance use treatment services, screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member

N. AAH arranges for the provision of Medications for Addiction Treatment (MAT) provided in primary care, inpatient hospitals, emergency departments, and other contracted medical settings

O. AAH arranges for the provision of emergency services necessary to stabilize the member for behavioral health/SUD and/or medical condition

P. AAH provides non-business hour, (including 24 hour/7 days per week) psychiatric emergency services coordinated through the Behavioral Health department. See policy MBR-062 Member Services Clinical Referral and Triage Process, and policy BH-002 Behavioral Health Services.

Q. The AAH Nurse Advice Line uses protocols to ensure that members who call the Advice Line displaying symptoms of psychiatric emergencies or requesting psychiatric emergency services are directed to appropriate care. This may include referring to a mental health evaluation team and/or law enforcement with authority to write a hold for psychiatric care. For the provision of behavioral health and SUD services, all medically necessary determinations for covered specialty mental health services and substance use disorder services provided by AAH shall be made in accordance with W&I Section 14184.4, and is considered medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain. (W&I Sec.14059.5)

R. AAH covers clinically appropriate NSMHS/SUD even when services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether the member meets criteria for NSMHS or that SMHS access or SUD criteria are met.

AAH covers clinically appropriate NSMHS/SUD services whether or not services are included in an individual treatment plan; whether or not the member has a co-occurring mental health condition and substance use disorder (SUD); and whether or not NSMHS and SMHS services are provided concurrently, (if those services are coordinated and not duplicated

S. AAH does not deny or disallow reimbursement for NSMHS/SUD services provided during the assessment process if the assessment determines that the member does not meet the criteria for NSMHS or meets the criteria for SMHS or SU

T. Clinically appropriate and covered NSMHS delivered by providers are covered Medi-Cal services whether or not the NSMHS were included in an individual treatment plan

U. AAH is responsible to:

1. provide Comprehensive Medical Case Management Services for members with NSMHS or SHMH needs, including coordination of care to ensure the provision of all medically necessary services, whether those services are delivered in the Alliance network or out of network.
2. cover and pay for medically necessary Medi-Cal covered physical health care services for a member receiving NSMHS and SMHS, whether those services are delivered within or outside of the Alliance’s provider network:
3. appropriately manage a member’s mental and physical health care, which includes, but is not limited to, medication reconciliation and the coordination of all medically necessary, contractually required Medi-Cal covered services, including mental health/SUD services, within and outside of the AAH provider network; and to
4. coordinate care with the ACBH service system.

V. Drug Medi-Cal (DMC) services are delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services through ACBH. These clinically appropriate and covered services are covered whether or not the member has a co-occurring mental health condition.

Any concurrent NSMHS and SMHS/SUD for adults, as well as children under 21 years of age, are coordinated between AAH and ACBH to ensure member choice. AAH arranges for the coordination with ACBH to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider, and vice versa

W. Members with established therapeutic relationships with an AAH provider may continue receiving NSMHS from the AAH provider (billed to the AAH), even if the member simultaneously receives SMHS/SUD from an ACBH or AAH provider (billed to AAH), (as long as the services are coordinated between the delivery systems and are non-duplicative.)

X. Alliance member informing materials (such as the Member Handbook,) clearly state that referral and prior authorization are not required for a member to seek an initial mental health assessment from an AAH network mental health ~~providers, and~~providers and notifies members of applicable policies.

Y. The Alliance ensures that its provider network is adequate to provide a full range of covered NSMHS to its pediatric and adult members, consistent with APL 21-006.

Z. Members referred for behavioral health treatment remain enrolled in the Alliance and the assigned PCP remains responsible for all necessary physical health care.

AA. The Alliance maintains a process of communication amongst the member's assigned PCP and mental health providers.

BB. The Alliance's case management team ensures internal communication and communication with the Alliance's contracted entities between all levels of care.

CC. The Alliance retains full responsibility for assuring continuity of care.

Assessment, Screening and Referrals

The Alliance has a process for assessing, screening, and referring members for behavioral health services. AAH does not require prior authorization for an initial mental health assessment.
AAH is obligated to cover the cost of an initial mental health assessment completed by an out of network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and access requirements.

Confidentiality

The Alliance provides reasonable protection of member's confidentiality that does not cause undue delay or disruption in care.

Medi-Cal Behavioral Health Care Coordination

A. Alameda Alliance for Health is obligated to cover and pay for mental health assessments for members with potential mental health disorders conducted by licensed mental health professionals as specified in the Medi-Cal Provider Manual.

1. This is in addition to the requirement that PCPs offer mental health services within their scope of practice.
2. The Alliance covers outpatient mental health services and coordinates care for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (assessed by a licensed mental health professional through the use of a Medi- Cal- approved clinical tool, transition of care tool, and sets of tools agreed upon by both the Alliance and its MHP), resulting from a mental health disorder, as defined in the current DSM.
3. AAH arranges for the provision of the following non-specialty mental health services (NSMHS):
   i Mental health evaluation and treatment, including individual, group and family psychotherapy;
   ii Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
   iii Outpatient services for purposes of monitoring drug therapy;
   iv Psychiatric consultation;
   v Outpatient laboratory, drugs, supplies, and supplements.
4. Conditions that the DSM identifies as relational problems (e.g., couples counseling, family counseling for relational problems) are not covered as part of the new benefit by the Alliance or the MHP.
5. All services must be provided in a culturally and linguistically appropriate manner.

B. The Alliance provides Alliance Medi-Cal ~~members~~members with outpatient mental health services as described in DHCS MMCD All Plan Letter 13-021, DHCS MMCD All Plan Letter 13-023, and all other members with both outpatient and inpatient behavioral health services.

C. The Alliance maintains a Memorandum of Understanding (MOU) with Alameda County Behavioral Health Care Services (ACBHCS) for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of behavioral health/SUD and medical services for Medi-Cal members enrolled in the Alliance. The MOU includes a process for resolving disputes between AAH and ACBHCS that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services (SMHS) and prescription drugs, while the dispute is being resolved. The dispute resolution process and liaison function will address issues related to behavioral health services for Alliance members. The MOU will include the following provisions:

1. ACBHCS will provide and be responsible for specialty mental health/SUD services as described in DHCS MMCD Policy Letter 00-001REV to Medi-Cal beneficiaries enrolled in the Alliance and Exhibit A, Attachment III, Section 5.6.
2. ACBHCS will provide emergency specialty mental services during regular business hours, which meet the criteria outlined in State regulations, Title 9, Section 1830.205 and 1830.210
3. Specify the entity responsible for establishing contracts detailing payment mechanisms with providers
4. Require coordinated case management and concurrent review by both the Alliance and ACBHCS for any medically necessary service requiring shared responsibility (such as partial hospitalization and residential treatment for eating disorders).
5. Specify procedures to ensure timely and complete exchange of information between the Alliance and ACBHCS for the purpose of medical and behavioral health care coordination. This procedure ensures the member's medical record is complete and that the Alliance can meet its care coordination obligations.
6. Specify the financial responsibility for the service.

Group Care Requirements for Behavioral Health

A. The Alliance will comply with SB 855, which enacts CA Health and Safety Code §1374.72 and §1374.721 Mental Health and Substance Use Disorder Coverage.

B. In accordance with CA Health and Safety Code §1374.72, the Alliance will cover medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing he 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:
    a. In accordance with the generally accepted standards of mental health and substance use disorder care.
    b. Clinically appropriate in terms of type, frequency, extent, site, and duration.
    c. 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.
C. The Alliance will not limit benefits or coverage for MH/SUD to short-term or acute treatment.
D. The Alliance will arrange coverage for out-of- network services for medically necessary treatment of a 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. The Alliance will continue to meet its obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.
E. The Alliance will not limit benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program. F. In accordance with CA Health and Safety Code §1374.721:
    a. The Alliance will base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care.
    b. The Alliance will apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.
    c. The Alliance will sponsor a formal education program by nonprofit clinical specialty associations to educate all plan staff and delegates contracted to review claims, conduct utilization review, or make medical necessity determinations.
    d. The Alliance and its delegates will conduct interrater reliability testing and run

CM. reports to achieve an interrater reliability pass rate of at least 90 percent. AAH complies with the requirement that contract provisions that reserve discretionary authority to the plan, or agent of the plan, to determine eligibility for benefits or coverage, interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with CA Health and Safety Code §1367.045 of this are void and unenforceable.

PROCEDURE

Identification/Diagnosis

A. PCPs are responsible for identifying Members with behavioral health conditions requiring professional treatment. Identification of these members can occur during routine physical exams through review of the past medical history or review of systems, or during any visit for acute or chronic conditions.

B. PCPs are responsible for diagnosing and treating Members' behavioral health conditions within their scope of practice.

C. Members presenting with complex or mixed psychiatric symptomatology that make the diagnosis uncertain must be referred to a behavioral health practitioner for assessment and diagnosis.

D. The Alliance ensures timely evaluation, screening, and diagnosis of members with ASD.

E. The Alliance has methods in place to ensure communication between and among member's mental health providers and medical providers. These methods help ensure appropriate evaluation, screening, diagnosis, and treatment for SED, SMI, and autism conditions.

F. Alliance members with both mental and medical conditions are screened, identified, and referred in a timely manner.
G. The Alliance has set standards to uphold timely evaluation, screening, and diagnosis of members. Specifically:
    1. Patients with ASD
    2. Members diagnosed with co-existing medical and mental health conditions.

H. The effectiveness of screening enrollees with co-existing conditions is monitored at least annually for members receiving mental health services. This monitoring includes review of timely access to treatment and any follow-up being done.

Treatment

A. PCPs are responsible for treating Members with behavioral health conditions within their scope of practice. Treatment includes the provision of appropriate psychotropic medications, as indicated. Typical behavioral health conditions within the scope of practice of PCPs include:
    1. Depression - uncomplicated depression responsive to first line anti-depressant medication.
    2. Anxiety - uncomplicated generalized anxiety requiring the short-term use of anxiolytics.

CM. Adjustment Reaction - grief reaction, anxiety, or other symptoms as a result of a negative life occurrence. The PCP is responsible for medication management, if necessary4. Attention Deficit Hyperactive Disorder (ADH–) - this disorder is evaluated by the PCP; however formal diagnosis and medication management of the disease may or may not be within the PCP's scope of practice.

B. The following conditions, when combined with significant impairment, are generally beyond the PCP's scope of practice and require a referral to a behavioral health practitioner for evaluation and diagnosis:

    1. Schizophrenia;
    2. Schizoaffective Disorder;
    3. Bipolar Disorder;
    4. AD–D - formal diagnosis and/or medical management;
    5. Depression with psychotic or anxiety features, or unresponsive to typical antidepressant medication;
    6. Obsessive Compulsive Disorder;
    7. Severe anxiety;

8. Any Member with symptoms suggestive of mental illness that cannot be definitively diagnosed by the PCP;
9. Pervasive Development Disorder or Autism;
10. Anorexia Nervosa (Behavioral component);
11. Bulimia Nervosa (Behavioral component); and
12. Any Member not responding as expected to prescribed psychotropic medications.

C. To ensure that high quality, effective care, vital clinical and demographic patient information will be provided by the PCP to the Behavioral Health Practitioner.

The Behavioral Health Practitioner is expected to provide written communication to the PCP periodically throughout the visits and when there are changes in the level of care. In additional, behavioral health providers should communicate with PCPs or other treating physicians any time that such communication is deemed clinically appropriate, examples are but are not limited to

D. :

1. Concerns for the patient's physician safety or the safety of others interacting with the patient.
2. Indication that the patient may be abusing prescription medication or illegal drugs.
3. Presentation of symptoms that may be medical in origin.
4. Indication of adverse reaction(s) to medication.

CM. Referral. PCPs and/or specialists, with the assistance of the Medical Services Department, are responsible for referring Members to the appropriate Mental Health Provider for treatment. B. For Medi-Cal Members, members are referred to the Alliance's Behavioral Health department who will then coordinate with County Mental Health Plan (ACBHCS) for assessment, diagnosis and treatment as needed. PCPs may also call the Alliance's Behavioral Health department or the Alameda County Behavioral Health (ACBH) for advice or consultation regarding Member behavioral health issues, including diagnostic or treatment consultation, or the appropriateness of a referral.

C. Providers and PCPs can also receive assistance in making referrals for behavioral health care through the Alliance by contacting Member Services.

D. Members may also self-refer to behavioral health practitioners for treatment. The Alliance Member Services can assist Members desiring to self-refer and/or with accessing behavioral health services as needed.

E. When members are referred to the Alliance's Complex Case Management (CCM) program, the Alliance's case management staff performs a General Assessment. During the assessment, the assigned case manager evaluates the member's mental health status, including review of psychosocial factors, cognitive functions, and depression. Referrals are made to behavioral health clinicians for case management members that meet specified criteria.

Care Coordination

A. The Utilization Management/Medical Services Department is responsible for managing the coordination of care for members receiving ongoing services with a behavioral health practitioner. Coordination activities include:
   1. Facilitating clinician-to-clinician conversations between the PCP and the behavioral health practitioner, as necessary;
   2. Maintaining liaison with the East Bay Regional Medical Center to:
      a. Assist members with developmental disabilities to understand and access services.
      b. Act as a central point of contact for questions, access and care concerns, and problem resolution as required by Welfare and Institutions Code 14182 9 (c) (10).
   3. Facilitating transfer of medical records between a treating Alliance physician and the behavioral health practitioner as necessary; and
   4. Other Care Coordination/Utilization Management services as needed to assure all appropriate services (home health, laboratory or other diagnostic testing, specialty referral, etc.) are available for the Member.

B. PCPs are responsible for direct coordination of the clinical care of the member in concert with the behavioral health practitioner through phone calls, transfer of medical records, and other specialty referrals as indicated.

The Alliance has processes in place to ensure appropriate communication and exchange of information between the plan's clinical case management staff and its contracted entities including delegates, IPA/medical groups, and facilitates. as it relates to behavioral health services and treatment for its members

C. :

• The Alliance clinical case management staff ensures there's coordination in care between the medical and mental health providers to improve the Member's diagnosis, treatment, and referral of mental health conditions in the medical setting.

D. The Alliance Utilization Management/Health Care Services Department is responsible for informing the PCP (assuming release of information consented to by the Member) upon learning that a Member has directly accessed an out of- network behavioral health practitioner without going through the PCP or the Alliance.

Care Coordination is also available for consultation regarding complex cases, members with co-existing medical conditions and mental disorders, and/or to assist with coordinating care with behavioral health practitioners, including county practitioners

E. .

F. The Alliance's case management team ensures internal communication and communication with the Alliance's contracted entities between all levels of care.
   1. Levels of care include but are not limited to inpatient care, partial hospitalization, outpatient care, day and residential treatment.
   2. Interdisciplinary rounds that include Behavioral Health are conducted by The Alliance Case Management staff and The Alliance Inpatient Utilization Management staff.

G. The Alliance upholds a coordination of care process that includes communication amongst providers between levels of care. This process and its accompanying standards are disseminated amongst the plan's providers.

Eating Disorders

A. AAH is responsible for all medically necessary physical health components of eating disorder treatment, and for providing or arranging medically necessary non-specialty mental health services (Non-Specialty Mental Health Services,) and specialty mental health services (SMHS) to its members.
B. AAH and ACBH will provide services necessary to correct or ameliorate eating disorders for members of all ages, including members under age 21.
C. Regarding members with eating disorders, AAH provides inpatient hospitalization for members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.
    a. AAH will also provide or arrange for NSMHS for members requiring these services.
D. AAH will cover and pay for emergency room professional services.
E. As additionally noted above, AAH will provide care coordination for medically necessary care for members, including locating, arranging, and following up to ensure services were rendered for partial hospitalization and residential eating disorder programs, when such treatment is medically necessary for a member.
F. AAH will coordinate with Alameda County of Behavioral Health (ACBH) to provide, arrange, and pay for medically necessary psychiatric inpatient hospitalization and outpatient SMHS.
    a. For partial hospitalization and residential eating disorder programs, AAH will coordinate with the ACBH to ensure coverage for medically necessary physical health components.
    b. AAH and ACBH mutually agree to arrangements to cover the cost of medically necessary services provided in partial hospitalization and residential eating disorder programs. This includes agreement on the services, unit costs, and total costs associated with an episode or case of eating disorder treatment.

Medications

A. AAH covers outpatient laboratory tests, drugs, supplies and supplements prescribed by the mental health providers in the AAH network, PCPs, and non-network physicians prescribing for members, including physician administered drugs administered by a health care professional in the clinic, physician's office or outpatient setting through the medical benefit, to assess and treat mental health conditions.

B. The Alliance is responsible for informing network pharmacies of the coverage status of medications and provides instructions on which entity to bill for specific psychotropic medications.

C. Alliance and non-network (prescribing for members,) physicians are responsible for writing prescriptions for needed medications, and providing any additional information required by the Alliance or Medi-Cal Rx to obtain a particular medication.

D. The Alliance covers Substance Use Disorder (SUD) services including medications for addiction treatment, (also known as Medication-Assisted Treatment, or MAT) when delivered in Primary Care Offices, Emergency Departments, inpatient hospitals, and other contracted medical settings.

Dispute Resolution

A. Regardless of the MOU status, AAH and ACBHCS must complete the plan level dispute resolution process within 15 business days of identifying the dispute.

Within three business days of receipt of a Request for Resolution from AAH or ACBHCS, DHCS will forward a copy of the Request for Resolution to the Director of AAH or ACBHCS via secure email

B. l.
    a. AAH will respond and provide relevant documents to the requesting party within 3business days.
    b. If ACBHCS fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by AAH. Conversely, if AAH fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by ACBHCS.

C. Within three business days after failure to resolve the dispute during that timeframe,
    a. AAH or ACBHCS must submit a written Request for Resolution to DHCS
    b. Request for Resolution will be signed by AAH CEO or CEO's designee.
    c. Request for Resolution must include:
        i. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the member by either AAH or the ACBHCS and the expected rate of payment for each type of service;
        ii. A history of the attempts to resolve the issue(s) with the ACBHCS;
        iii. Justification for AAH's desired remedy; and
        iv. Any additional documentation that AAH deems relevant to resolve the disputed issue(s), if applicable.
        v. The Request for Resolution must be submitted via secure email to MCQMD@dhcs.ca.gov.

D. Within 20 business days from the third business day after the Notification date, DHCS will communicate the final decision via secure email to the AAH's CEO (or the CEO's designee, if the designee submitted the Request for Resolution) and the ACBHCS's Director (or the Director's designee, if the designee submitted the Request for Resolution).

E. Any such action required from the DHCS of either AAH or ACBHCS must be taken no later than the next business day following the date of the decision.

F. The Alliance may submit a request for resolution to DHCS, in accordance with the rules governing resolution of disputes in Title 9, CCR, Section 1850.505, when a dispute with ACBHCS about Alliance contractual obligations cannot be satisfactorily resolved for the Alliance's Medi-Cal members.

G. AAH is contractually responsible for the provision of case management and care coordination and continuity of care for all medically necessary services a member needs, including those services that are the subject of a dispute between AAH and ACBHCS.

H. This includes assurance that new members going through transition of care with acute, serious, or chronic mental health conditions receiving services from a non-participating to participating provider are kept safe throughout the transition.

I. Any dispute between the Alliance and ACBHCS shall not delay case management and care coordination, as well as coverage of medically necessary specialty mental health services, physical health services, or related prescription drugs and laboratory, radiological or radioisotope services to Alliance members.

J. During resolution of the dispute, AAH will be responsible for working with ACBHCS to ensure that there is no duplication of SMHS, for which ACBHCS will provide case management.

Expedited Dispute Resolution Process

A. AAH may seek to enter into an expedited dispute resolution process if a member has not received a disputed service(s) and AAH and/or ACBHCS determine that the Routine Dispute Resolution Process timeframe would result in serious jeopardy to the member's life, health, or ability to attain, maintain, or regain maximum function.
   a. AAH and ACBHCS will have one business day after identification of an expedited dispute to attempt to resolve the dispute at the plan level.
   b. Within one business day after a failure to resolve the dispute in that timeframe, both plans will separately submit a Request for Resolution to DHCS, as set out above, including an affirmation of the stated jeopardy to the member.
   c. If ACBHCS fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by AAH. Conversely, if AAH fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by ACBHCS.

Financial Liability

If DHCS' decision includes a finding that the unsuccessful party is financially liable to the other party for services, AAH or ACBHCS is required to comply with the requirements in Title 9, California Code of Regulations (CCR), section 1850.530.

Confidentiality

A. The Alliance maintains Business Associates Agreements (BAA) with its contracted provider network. Provisions in these agreements ensure the Alliance's members medical information is kept confidential as medical information is shared as part of the care coordination process.

B. The Alliance's Member Services department maintains an information release form for authorization to release mental health records/information.

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

AB 88 Mental Illness (HSC) 1374.72 – Health Plans that provide hospital, medical or surgical coverage must cover the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age and of serious emotional disturbance in a child. The law lists nine (9) mental illnesses to be covered:

1. anorexia and bulimia
2. bipolar disorder,
3. major depression,
4. obsessive compulsive disorder,
5. panic disorder,
6. pervasive developmental disorder or autism,
7. schizoaffective disorder,
8. schizophrenia

Behavioral Health Provider – the Alliance network of behavioral health care providers.

Behavioral Health Services includes the range of assessment, referral, treatment and follow up services for mental health and substance abuse disorders.

Crisis Intervention is sudden short-term medically necessary treatment required to restore a member in crisis to the pre-crisis level of functioning. The member suffers a sudden mental condition which interferes with the member's daily activities from which the member is incapable of recovering without assistance.

Mental Health Services may be provided on an inpatient and outpatient basis and include treatable mental disorders such as severe mental illness and stress related conditions.

Regional Center of the East Bay (RCEB) – The Regional Center of the East Bay (RCEB) is a private, non-profit corporation under contract with the California Department of Developmental Services. RCEB works in partnership with many individuals and other agencies to plan and coordinate services and supports for people with developmental disabilities. A community-based Board of Directo–s - which includes individuals with developmental disabilities, family members and community leaders - provides guidance and leadership.

AFFECTED DEPARTMENTS/PARTIES

Provider Services
Utilization Management
Case Management
Behavioral Health
Member Services

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENT

BH-01 Behavioral Health Services
BH-02 Behavioral Health Services
CM-001 CCM Identification Screening Enrollment and Assessment
CM-004 Care Coordination of Services
MBR-062 Member Services Clinical Referral and Triage Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2006, 4/1/2011, 6/1/2011, 9/7/2012, 3/5/2013, 7/12/2013, 12/26/2013, 12/30/2013, 4/7/2014, 4/13/2015. 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 3/18/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 9/19/2023

REFERENCES

1. DHCS Contract, Amendment 17, Exhibit A, Attachments 10. Provision 8.E; 11.Provision 6. A and B; 12. Provision 3 and Attachment 21
2. MMCD Policy Letter No. 00-001 REV. MCMC Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program
3. MMCD All Plan Letter 13-021 Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services
4. MMCD All Plan Letter 13-023 Continuity of Care for Medi-Cal Beneficiaries who transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care
5. MMCD All Plan Letter 21-002 Implementation of Senate Bill 855, Mental Health and Substance Use Disorder Coverage
6. NCQA QI 9 Standard Continuity and Coordination Between Medical Care and Behavioral HealthCare
7. DHCS All Plan Letter 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders
8. DHCS All Plan Letter 22-005 No Wrong Door for Mental Health Services
9. DHCS All Plan Letter 22-006 Medi-Cal Managed Care Health Plan Responsibilities for NSMHS
10. Medicaid Mental Health Parity Final Rule (CMS-2333-F)
11. Behavioral Health Information Notice (BHIN) 21-073
12. California W&I Code sections 14059.5 and 14184.402
13. United States Code (USC) Section 1396d(r)(5) of Title 42
14. CCR Section 53855 of Title 22

MONITORING

The Compliance, Utilization Management and Behavioral Health Departments 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	BH-005
Policy Name	Care Coordination – Behavioral Health
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Senior Director, Behavioral Health Care Services
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	TBD

POLICY STATEMENT

A. Alameda Alliance for Health (the Alliance) Primary Care Providers (PCPs) are required to provide behavioral health and/or substance abuse services, including diagnosis and treatment, within their scope of practice.

B. PCPs are required to provide mental health (MH) and substance use disorder (SUD) screening for their assigned members.

1. If the PCP cannot perform the mental health/SUD assessment, they are required to refer the member to an appropriate provider and ensure that the referral to the appropriate delivery system for mental health services, whether to the Alliance's Behavioral Health department, or to the Alameda County Behavioral Health services.

2. Members with positive screening results may be further assessed by the PCP or by referral to the appropriate mental health/SUD delivery system.

C. PCPs treating Members with behavioral health SUD needs beyond the PCP's scope of practice, in terms of diagnosis or treatment, must refer the member to the appropriate Mental Health/SUD Provider.

1. Medi-Cal – The Alliance's Behavioral Health department which will in turn coordinate with the Alameda County Behavioral Health (ACBH

2. All other Lines of Business – The Alliance's Behavioral Health department.

D. At any time, members can choose to seek and obtain a mental health/SUD assessment from a licensed mental health provider within the AAH network.

E. AAH furnishes all services defined as appropriate and medically necessary under Medicaid 42 USC Section 1396d(a) necessary to correct or ameliorate health conditions, including behavioral health/SUD conditions, discovered by a screening service, regardless of whether those services are covered in the California Medi-Cal plan.

F. Behavioral Health/SUD services need not be curative or restorative to ameliorate a behavioral health condition, consistent with federal guidance from Centers for Medicare and Medicaid Services (CMS.)

G. Behavioral/SUD Health services that sustain, support, improve or make more tolerable a behavioral health/SUD condition are considered to ameliorate the condition, and are thus medically necessary. They are also covered as Early and Periodic Screening, Diagnostic and Treatment, (EPSDT) services.

H. For members who are 21 years of age or older, services are considered medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

I. AAH arranges for the provision of Non-Specialty Mental Health Services (NSMHS) and SUD services for all members, including the following populations:

1. Members who are 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM);

2. Members who are under the age of 21, to the extent they are eligible for services through the Medicaid EPSDT benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;

3. Members who are under the age of 21, with specified risk factors or with persistent mental health symptoms in absence of a mental health disorder, are subject to psychotherapy, and

4. Members of any age with potential mental health disorders not yet diagnosed.

J. AAH covers up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth.

K. AAH arranges for the provision of medically necessary SMHS for members who meet access criteria for SMHS as described in the Behavioral Health Information Notice (BHIN) 21-073

L. AAH arranges for the provision of the following non-specialty mental health services (NSMHS):

1. Mental health evaluation and treatment, including individual, group and family psychotherapy;
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for purposes of monitoring drug therapy;
4. Psychiatric consultation;
5. Outpatient laboratory, drugs, supplies, and supplements.

M. Services are defined as “medically necessary” or a “medical necessity” in accordance with the California Welfare and Institutions Code (W&I) sections 14059.5 and 14184.402, for individuals under 21, a service is “medically necessary” or a ‘medical necessity” when the service meets the standards set forth in Section 1396d©(5) of Title 42 of the United States Code (U.S.C.) This includes NSMHS and SUD services and are covered by AAH as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

AAH covers and pays for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations. This includes facility and professional services and facility charges claimed by emergency departments, all professional physical, mental, and substance use treatment services, screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member

N. AAH arranges for the provision of Medications for Addiction Treatment (MAT) provided in primary care, inpatient hospitals, emergency departments, and other contracted medical settings

O. AAH arranges for the provision of emergency services necessary to stabilize the member for behavioral health/SUD and/or medical condition

P. AAH provides non-business hour, (including 24 hour/7 days per week) psychiatric emergency services coordinated through the Behavioral Health department. See policy MBR-062 Member Services Clinical Referral and Triage Process, and policy BH-002 Behavioral Health Services.

Q. The AAH Nurse Advice Line uses protocols to ensure that members who call the Advice Line displaying symptoms of psychiatric emergencies or requesting psychiatric emergency services are directed to appropriate care. This may include referring to a mental health evaluation team and/or law enforcement with authority to write a hold for psychiatric care. For the provision of behavioral health and SUD services, all medically necessary determinations for covered specialty mental health services and substance use disorder services provided by AAH shall be made in accordance with W&I Section 14184.4, and is considered medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain. (W&I Sec.14059.5)

R. AAH covers clinically appropriate NSMHS/SUD even when services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether the member meets criteria for NSMHS or that SMHS access or SUD criteria are met.

AAH covers clinically appropriate NSMHS/SUD services whether or not services are included in an individual treatment plan; whether or not the member has a co-occurring mental health condition and substance use disorder (SUD); and whether or not NSMHS and SMHS services are provided concurrently, (if those services are coordinated and not duplicated

S. AAH does not deny or disallow reimbursement for NSMHS/SUD services provided during the assessment process if the assessment determines that the member does not meet the criteria for NSMHS or meets the criteria for SMHS or SU

T. Clinically appropriate and covered NSMHS delivered by providers are covered Medi-Cal services whether or not the NSMHS were included in an individual treatment plan

U. AAH is responsible to:

1. provide Comprehensive Medical Case Management Services for members with NSMHS or SHMH needs, including coordination of care to ensure the provision of all medically necessary services, whether those services are delivered in the Alliance network or out of network.
2. cover and pay for medically necessary Medi-Cal covered physical health care services for a member receiving NSMHS and SMHS, whether those services are delivered within or outside of the Alliance’s provider network:
3. appropriately manage a member’s mental and physical health care, which includes, but is not limited to, medication reconciliation and the coordination of all medically necessary, contractually required Medi-Cal covered services, including mental health/SUD services, within and outside of the AAH provider network; and to
4. coordinate care with the ACBH service system.

V. Drug Medi-Cal (DMC) services are delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services through ACBH. These clinically appropriate and covered services are covered whether or not the member has a co-occurring mental health condition.

Any concurrent NSMHS and SMHS/SUD for adults, as well as children under 21 years of age, are coordinated between AAH and ACBH to ensure member choice. AAH arranges for the coordination with ACBH to facilitate care transitions and guide referrals for members receiving NSMHS to transition to a SMHS provider, and vice versa

W. Members with established therapeutic relationships with an AAH provider may continue receiving NSMHS from the AAH provider (billed to the AAH), even if the member simultaneously receives SMHS/SUD from an ACBH or AAH provider (billed to AAH), (as long as the services are coordinated between the delivery systems and are non-duplicative.)

X. Alliance member informing materials (such as the Member Handbook,) clearly state that referral and prior authorization are not required for a member to seek an initial mental health assessment from an AAH network mental health providers and notifies members of applicable policies.

Y. The Alliance ensures that its provider network is adequate to provide a full range of covered NSMHS to its pediatric and adult members, consistent with APL 21-006.

Z. Members referred for behavioral health treatment remain enrolled in the Alliance and the assigned PCP remains responsible for all necessary physical health care.

AA. The Alliance maintains a process of communication amongst the member's assigned PCP and mental health providers.

BB. The Alliance's case management team ensures internal communication and communication with the Alliance's contracted entities between all levels of care.

CC. The Alliance retains full responsibility for assuring continuity of care.

Assessment, Screening and Referrals

The Alliance has a process for assessing, screening, and referring members for behavioral health services. AAH does not require prior authorization for an initial mental health assessment.
AAH is obligated to cover the cost of an initial mental health assessment completed by an out of network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and access requirements.

Confidentiality

The Alliance provides reasonable protection of member's confidentiality that does not cause undue delay or disruption in care.

Medi-Cal Behavioral Health Care Coordination

A. Alameda Alliance for Health is obligated to cover and pay for mental health assessments for members with potential mental health disorders conducted by licensed mental health professionals as specified in the Medi-Cal Provider Manual.

1. This is in addition to the requirement that PCPs offer mental health services within their scope of practice.
2. The Alliance covers outpatient mental health services and coordinates care for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (assessed by a licensed mental health professional through the use of a Medi- Cal- approved clinical tool, transition of care tool, and sets of tools agreed upon by both the Alliance and its MHP), resulting from a mental health disorder, as defined in the current DSM.
3. AAH arranges for the provision of the following non-specialty mental health services (NSMHS):
    - i Mental health evaluation and treatment, including individual, group and family psychotherapy;
    - ii Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
    - iii Outpatient services for purposes of monitoring drug therapy;
    - iv Psychiatric consultation;
    - v Outpatient laboratory, drugs, supplies, and supplements.
4. Conditions that the DSM identifies as relational problems (e.g., couples counseling, family counseling for relational problems) are not covered as part of the new benefit by the Alliance or the MHP.
5. All services must be provided in a culturally and linguistically appropriate manner.

B. The Alliance provides Alliance Medi-Cal members with outpatient mental health services as described in DHCS MMCD All Plan Letter 13-021, DHCS MMCD All Plan Letter 13-023, and all other members with both outpatient and inpatient behavioral health services.

C. The Alliance maintains a Memorandum of Understanding (MOU) with Alameda County Behavioral Health Care Services (ACBHCS) for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of behavioral health/SUD and medical services for Medi-Cal members enrolled in the Alliance. The MOU includes a process for resolving disputes between AAH and ACBHCS that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services (SMHS) and prescription drugs, while the dispute is being resolved. The dispute resolution process and liaison function will address issues related to behavioral health services for Alliance members. The MOU will include the following provisions:

1. ACBHCS will provide and be responsible for specialty mental health/SUD services as described in DHCS MMCD Policy Letter 00-001REV to Medi-Cal beneficiaries enrolled in the Alliance and Exhibit A, Attachment III, Section 5.6.
2. ACBHCS will provide emergency specialty mental services during regular business hours, which meet the criteria outlined in State regulations, Title 9, Section 1830.205 and 1830.210
3. Specify the entity responsible for establishing contracts detailing payment mechanisms with providers
4. Require coordinated case management and concurrent review by both the Alliance and ACBHCS for any medically necessary service requiring shared responsibility (such as partial hospitalization and residential treatment for eating disorders).
5. Specify procedures to ensure timely and complete exchange of information between the Alliance and ACBHCS for the purpose of medical and behavioral health care coordination. This procedure ensures the member's medical record is complete and that the Alliance can meet its care coordination obligations.
6. Specify the financial responsibility for the service.

Group Care Requirements for Behavioral Health

A. The Alliance will comply with SB 855, which enacts CA Health and Safety Code §1374.72 and §1374.721 Mental Health and Substance Use Disorder Coverage.

B. In accordance with CA Health and Safety Code §1374.72, the Alliance will cover medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing he 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:
    a. In accordance with the generally accepted standards of mental health and substance use disorder care.
    b. Clinically appropriate in terms of type, frequency, extent, site, and duration.
    c. 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.
C. The Alliance will not limit benefits or coverage for MH/SUD to short-term or acute treatment.
D. The Alliance will arrange coverage for out-of- network services for medically necessary treatment of a 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. The Alliance will continue to meet its obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.
E. The Alliance will not limit benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program. F. In accordance with CA Health and Safety Code §1374.721:
    a. The Alliance will base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care.
    b. The Alliance will apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.
    c. The Alliance will sponsor a formal education program by nonprofit clinical specialty associations to educate all plan staff and delegates contracted to review claims, conduct utilization review, or make medical necessity determinations.
    d. The Alliance and its delegates will conduct interrater reliability testing and run

CM. reports to achieve an interrater reliability pass rate of at least 90 percent. AAH complies with the requirement that contract provisions that reserve discretionary authority to the plan, or agent of the plan, to determine eligibility for benefits or coverage, interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with CA Health and Safety Code §1367.045 of this are void and unenforceable.

PROCEDURE

Identification/Diagnosis

A. PCPs are responsible for identifying Members with behavioral health conditions requiring professional treatment. Identification of these members can occur during routine physical exams through review of the past medical history or review of systems, or during any visit for acute or chronic conditions.

B. PCPs are responsible for diagnosing and treating Members' behavioral health conditions within their scope of practice.

C. Members presenting with complex or mixed psychiatric symptomatology that make the diagnosis uncertain must be referred to a behavioral health practitioner for assessment and diagnosis.

D. The Alliance ensures timely evaluation, screening, and diagnosis of members with ASD.

E. The Alliance has methods in place to ensure communication between and among member's mental health providers and medical providers. These methods help ensure appropriate evaluation, screening, diagnosis, and treatment for SED, SMI, and autism conditions.

F. Alliance members with both mental and medical conditions are screened, identified, and referred in a timely manner.
G. The Alliance has set standards to uphold timely evaluation, screening, and diagnosis of members. Specifically:
    1. Patients with ASD
    2. Members diagnosed with co-existing medical and mental health conditions.

H. The effectiveness of screening enrollees with co-existing conditions is monitored at least annually for members receiving mental health services. This monitoring includes review of timely access to treatment and any follow-up being done.

Treatment

A. PCPs are responsible for treating Members with behavioral health conditions within their scope of practice. Treatment includes the provision of appropriate psychotropic medications, as indicated. Typical behavioral health conditions within the scope of practice of PCPs include:
    1. Depression - uncomplicated depression responsive to first line anti-depressant medication.
    2. Anxiety - uncomplicated generalized anxiety requiring the short-term use of anxiolytics.

CM. Adjustment Reaction - grief reaction, anxiety, or other symptoms as a result of a negative life occurrence. The PCP is responsible for medication management, if necessary4. Attention Deficit Hyperactive Disorder (ADH–) - this disorder is evaluated by the PCP; however formal diagnosis and medication management of the disease may or may not be within the PCP's scope of practice.

B. The following conditions, when combined with significant impairment, are generally beyond the PCP's scope of practice and require a referral to a behavioral health practitioner for evaluation and diagnosis:

    1. Schizophrenia;
    2. Schizoaffective Disorder;
    3. Bipolar Disorder;
    4. AD–D - formal diagnosis and/or medical management;
    5. Depression with psychotic or anxiety features, or unresponsive to typical antidepressant medication;
    6. Obsessive Compulsive Disorder;
    7. Severe anxiety;

8. Any Member with symptoms suggestive of mental illness that cannot be definitively diagnosed by the PCP;
9. Pervasive Development Disorder or Autism;
10. Anorexia Nervosa (Behavioral component);
11. Bulimia Nervosa (Behavioral component); and
12. Any Member not responding as expected to prescribed psychotropic medications.

C. To ensure that high quality, effective care, vital clinical and demographic patient information will be provided by the PCP to the Behavioral Health Practitioner.

The Behavioral Health Practitioner is expected to provide written communication to the PCP periodically throughout the visits and when there are changes in the level of care. In additional, behavioral health providers should communicate with PCPs or other treating physicians any time that such communication is deemed clinically appropriate, examples are but are not limited to

D. :

1. Concerns for the patient's physician safety or the safety of others interacting with the patient.
2. Indication that the patient may be abusing prescription medication or illegal drugs.
3. Presentation of symptoms that may be medical in origin.
4. Indication of adverse reaction(s) to medication.

CM. Referral. PCPs and/or specialists, with the assistance of the Medical Services Department, are responsible for referring Members to the appropriate Mental Health Provider for treatment. B. For Medi-Cal Members, members are referred to the Alliance's Behavioral Health department who will then coordinate with County Mental Health Plan (ACBHCS) for assessment, diagnosis and treatment as needed. PCPs may also call the Alliance's Behavioral Health department or the Alameda County Behavioral Health (ACBH) for advice or consultation regarding Member behavioral health issues, including diagnostic or treatment consultation, or the appropriateness of a referral.

C. Providers and PCPs can also receive assistance in making referrals for behavioral health care through the Alliance by contacting Member Services.

D. Members may also self-refer to behavioral health practitioners for treatment. The Alliance Member Services can assist Members desiring to self-refer and/or with accessing behavioral health services as needed.

E. When members are referred to the Alliance's Complex Case Management (CCM) program, the Alliance's case management staff performs a General Assessment. During the assessment, the assigned case manager evaluates the member's mental health status, including review of psychosocial factors, cognitive functions, and depression. Referrals are made to behavioral health clinicians for case management members that meet specified criteria.

Care Coordination

A. The Utilization Management/Medical Services Department is responsible for managing the coordination of care for members receiving ongoing services with a behavioral health practitioner. Coordination activities include:
   1. Facilitating clinician-to-clinician conversations between the PCP and the behavioral health practitioner, as necessary;
   2. Maintaining liaison with the East Bay Regional Medical Center to:
      a. Assist members with developmental disabilities to understand and access services.
      b. Act as a central point of contact for questions, access and care concerns, and problem resolution as required by Welfare and Institutions Code 14182 9 (c) (10).
   3. Facilitating transfer of medical records between a treating Alliance physician and the behavioral health practitioner as necessary; and
   4. Other Care Coordination/Utilization Management services as needed to assure all appropriate services (home health, laboratory or other diagnostic testing, specialty referral, etc.) are available for the Member.

B. PCPs are responsible for direct coordination of the clinical care of the member in concert with the behavioral health practitioner through phone calls, transfer of medical records, and other specialty referrals as indicated.

The Alliance has processes in place to ensure appropriate communication and exchange of information between the plan's clinical case management staff and its contracted entities including delegates, IPA/medical groups, and facilitates. as it relates to behavioral health services and treatment for its members

C. :

• The Alliance clinical case management staff ensures there's coordination in care between the medical and mental health providers to improve the Member's diagnosis, treatment, and referral of mental health conditions in the medical setting.

D. The Alliance Utilization Management/Health Care Services Department is responsible for informing the PCP (assuming release of information consented to by the Member) upon learning that a Member has directly accessed an out of- network behavioral health practitioner without going through the PCP or the Alliance.

Care Coordination is also available for consultation regarding complex cases, members with co-existing medical conditions and mental disorders, and/or to assist with coordinating care with behavioral health practitioners, including county practitioners

E. .

F. The Alliance's case management team ensures internal communication and communication with the Alliance's contracted entities between all levels of care.
   1. Levels of care include but are not limited to inpatient care, partial hospitalization, outpatient care, day and residential treatment.
   2. Interdisciplinary rounds that include Behavioral Health are conducted by The Alliance Case Management staff and The Alliance Inpatient Utilization Management staff.

G. The Alliance upholds a coordination of care process that includes communication amongst providers between levels of care. This process and its accompanying standards are disseminated amongst the plan's providers.

Eating Disorders

A. AAH is responsible for all medically necessary physical health components of eating disorder treatment, and for providing or arranging medically necessary non-specialty mental health services (Non-Specialty Mental Health Services,) and specialty mental health services (SMHS) to its members.
B. AAH and ACBH will provide services necessary to correct or ameliorate eating disorders for members of all ages, including members under age 21.
C. Regarding members with eating disorders, AAH provides inpatient hospitalization for members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.
    a. AAH will also provide or arrange for NSMHS for members requiring these services.
D. AAH will cover and pay for emergency room professional services.
E. As additionally noted above, AAH will provide care coordination for medically necessary care for members, including locating, arranging, and following up to ensure services were rendered for partial hospitalization and residential eating disorder programs, when such treatment is medically necessary for a member.
F. AAH will coordinate with Alameda County of Behavioral Health (ACBH) to provide, arrange, and pay for medically necessary psychiatric inpatient hospitalization and outpatient SMHS.
    a. For partial hospitalization and residential eating disorder programs, AAH will coordinate with the ACBH to ensure coverage for medically necessary physical health components.
    b. AAH and ACBH mutually agree to arrangements to cover the cost of medically necessary services provided in partial hospitalization and residential eating disorder programs. This includes agreement on the services, unit costs, and total costs associated with an episode or case of eating disorder treatment.

Medications

A. AAH covers outpatient laboratory tests, drugs, supplies and supplements prescribed by the mental health providers in the AAH network, PCPs, and non-network physicians prescribing for members, including physician administered drugs administered by a health care professional in the clinic, physician's office or outpatient setting through the medical benefit, to assess and treat mental health conditions.

B. The Alliance is responsible for informing network pharmacies of the coverage status of medications and provides instructions on which entity to bill for specific psychotropic medications.

C. Alliance and non-network (prescribing for members,) physicians are responsible for writing prescriptions for needed medications, and providing any additional information required by the Alliance or Medi-Cal Rx to obtain a particular medication.

D. The Alliance covers Substance Use Disorder (SUD) services including medications for addiction treatment, (also known as Medication-Assisted Treatment, or MAT) when delivered in Primary Care Offices, Emergency Departments, inpatient hospitals, and other contracted medical settings.

Dispute Resolution

A. Regardless of the MOU status, AAH and ACBHCS must complete the plan level dispute resolution process within 15 business days of identifying the dispute.

Within three business days of receipt of a Request for Resolution from AAH or ACBHCS, DHCS will forward a copy of the Request for Resolution to the Director of AAH or ACBHCS via secure email

B. l.
    a. AAH will respond and provide relevant documents to the requesting party within 3business days.
    b. If ACBHCS fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by AAH. Conversely, if AAH fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by ACBHCS.

C. Within three business days after failure to resolve the dispute during that timeframe,
    a. AAH or ACBHCS must submit a written Request for Resolution to DHCS
    b. Request for Resolution will be signed by AAH CEO or CEO's designee.
    c. Request for Resolution must include:
        i. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the member by either AAH or the ACBHCS and the expected rate of payment for each type of service;
        ii. A history of the attempts to resolve the issue(s) with the ACBHCS;
        iii. Justification for AAH's desired remedy; and
        iv. Any additional documentation that AAH deems relevant to resolve the disputed issue(s), if applicable.
        v. The Request for Resolution must be submitted via secure email to MCQMD@dhcs.ca.gov.

D. Within 20 business days from the third business day after the Notification date, DHCS will communicate the final decision via secure email to the AAH's CEO (or the CEO's designee, if the designee submitted the Request for Resolution) and the ACBHCS's Director (or the Director's designee, if the designee submitted the Request for Resolution).

E. Any such action required from the DHCS of either AAH or ACBHCS must be taken no later than the next business day following the date of the decision.

F. The Alliance may submit a request for resolution to DHCS, in accordance with the rules governing resolution of disputes in Title 9, CCR, Section 1850.505, when a dispute with ACBHCS about Alliance contractual obligations cannot be satisfactorily resolved for the Alliance's Medi-Cal members.

G. AAH is contractually responsible for the provision of case management and care coordination and continuity of care for all medically necessary services a member needs, including those services that are the subject of a dispute between AAH and ACBHCS.

H. This includes assurance that new members going through transition of care with acute, serious, or chronic mental health conditions receiving services from a non-participating to participating provider are kept safe throughout the transition.

I. Any dispute between the Alliance and ACBHCS shall not delay case management and care coordination, as well as coverage of medically necessary specialty mental health services, physical health services, or related prescription drugs and laboratory, radiological or radioisotope services to Alliance members.

J. During resolution of the dispute, AAH will be responsible for working with ACBHCS to ensure that there is no duplication of SMHS, for which ACBHCS will provide case management.

Expedited Dispute Resolution Process

A. AAH may seek to enter into an expedited dispute resolution process if a member has not received a disputed service(s) and AAH and/or ACBHCS determine that the Routine Dispute Resolution Process timeframe would result in serious jeopardy to the member's life, health, or ability to attain, maintain, or regain maximum function.
   a. AAH and ACBHCS will have one business day after identification of an expedited dispute to attempt to resolve the dispute at the plan level.
   b. Within one business day after a failure to resolve the dispute in that timeframe, both plans will separately submit a Request for Resolution to DHCS, as set out above, including an affirmation of the stated jeopardy to the member.
   c. If ACBHCS fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by AAH. Conversely, if AAH fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by ACBHCS.

Financial Liability

If DHCS' decision includes a finding that the unsuccessful party is financially liable to the other party for services, AAH or ACBHCS is required to comply with the requirements in Title 9, California Code of Regulations (CCR), section 1850.530.

Confidentiality

A. The Alliance maintains Business Associates Agreements (BAA) with its contracted provider network. Provisions in these agreements ensure the Alliance's members medical information is kept confidential as medical information is shared as part of the care coordination process.

B. The Alliance's Member Services department maintains an information release form for authorization to release mental health records/information.

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

AB 88 Mental Illness (HSC) 1374.72 – Health Plans that provide hospital, medical or surgical coverage must cover the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age and of serious emotional disturbance in a child. The law lists nine (9) mental illnesses to be covered:

1. anorexia and bulimia
2. bipolar disorder,
3. major depression,
4. obsessive compulsive disorder,
5. panic disorder,
6. pervasive developmental disorder or autism,
7. schizoaffective disorder,
8. schizophrenia

Behavioral Health Provider – the Alliance network of behavioral health care providers.

Behavioral Health Services includes the range of assessment, referral, treatment and follow up services for mental health and substance abuse disorders.

Crisis Intervention is sudden short-term medically necessary treatment required to restore a member in crisis to the pre-crisis level of functioning. The member suffers a sudden mental condition which interferes with the member's daily activities from which the member is incapable of recovering without assistance.

Mental Health Services may be provided on an inpatient and outpatient basis and include treatable mental disorders such as severe mental illness and stress related conditions.

Regional Center of the East Bay (RCEB) – The Regional Center of the East Bay (RCEB) is a private, non-profit corporation under contract with the California Department of Developmental Services. RCEB works in partnership with many individuals and other agencies to plan and coordinate services and supports for people with developmental disabilities. A community-based Board of Directo–s - which includes individuals with developmental disabilities, family members and community leaders - provides guidance and leadership.

AFFECTED DEPARTMENTS/PARTIES

Provider Services
Utilization Management
Case Management
Behavioral Health
Member Services

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENT

BH-01 Behavioral Health Services
BH-02 Behavioral Health Services
CM-001 CCM Identification Screening Enrollment and Assessment
CM-004 Care Coordination of Services
MBR-062 Member Services Clinical Referral and Triage Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2006, 4/1/2011, 6/1/2011, 9/7/2012, 3/5/2013, 7/12/2013, 12/26/2013, 12/30/2013, 4/7/2014, 4/13/2015. 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 3/18/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 9/19/2023

REFERENCES

1. DHCS Contract, Amendment 17, Exhibit A, Attachments 10. Provision 8.E; 11.Provision 6. A and B; 12. Provision 3 and Attachment 21
2. MMCD Policy Letter No. 00-001 REV. MCMC Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program
3. MMCD All Plan Letter 13-021 Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services
4. MMCD All Plan Letter 13-023 Continuity of Care for Medi-Cal Beneficiaries who transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care
5. MMCD All Plan Letter 21-002 Implementation of Senate Bill 855, Mental Health and Substance Use Disorder Coverage
6. NCQA QI 9 Standard Continuity and Coordination Between Medical Care and Behavioral HealthCare
7. DHCS All Plan Letter 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders
8. DHCS All Plan Letter 22-005 No Wrong Door for Mental Health Services
9. DHCS All Plan Letter 22-006 Medi-Cal Managed Care Health Plan Responsibilities for NSMHS
10. Medicaid Mental Health Parity Final Rule (CMS-2333-F)
11. Behavioral Health Information Notice (BHIN) 21-073
12. California W&I Code sections 14059.5 and 14184.402
13. United States Code (USC) Section 1396d(r)(5) of Title 42
14. CCR Section 53855 of Title 22

MONITORING

The Compliance, Utilization Management and Behavioral Health Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	~~UM-013~~BH-006
Policy Name	Coordination of Care – Substance Abuse
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	~~Medical Director~~Senior Director, BH Services
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	~~6/20/2023~~TBD

POLICY STATEMENT

A. Alameda Alliance for Health (the Alliance) PCPs are responsible for identifying Members with active or potential substance abuse problems.
B. Once Members are identified, PCPs are responsible for providing services for the substance abuse problem within their scope of practice (counseling and/or treatment) and for performing the appropriate medical work-up given the nature of the substance abuse problem.
C. PCPs are also responsible, with the assistance of the Alliance, for referring Members with substance abuse problems to an appropriate treatment practitioner.
D. Members referred for substance abuse treatment remain enrolled in the Alliance and the assigned PCP remains responsible for all necessary health care.
E. The Alliance does not require prior authorization for referral to Substance Abuse Disorder (SUD) evaluation or treatment.

PROCEDURE

A. Acute medical conditions related to alcohol or substance abuse.
    1. Medically necessary care for acute medical conditions related to alcohol or substance abuse, such as delirium tremens or gastrointestinal hemorrhage, is provided by the PCP or by specialist referral if necessary.
    2. Members are referred for outpatient treatment or transferred to a mental health practitioner when medically stable.

B. PCPs are responsible for identifying Members with substance abuse problems.

1. PCPs must include assessment of substance abuse during the initial health evaluation performed within 120 days of enrollment (see CLS-008 Member Assessment of Cultural and Linguistic Needs).
2. Subsequent contact with the Member also affords PCPs the opportunity for evaluation of the Member's health and questions regarding substance abuse problems.
3. PCPs provide Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) per the processes outlined in AAH policy HED-006 SABIRT, and APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment.
    a. If a provider is unable to provide SABIRT, the PCP refers the Member to a provider who can provide SABIRT services. The referral and subsequent treatment do not require prior authorization.

C. PCPs should consider substance abuse as a potential issue for Members that present with the following conditions, history, and/or requests:
1. Elevated liver enzymes without evidence of a specific causal factor such as hepatitis, other viral illnesses, medication induced, etc.
2. Repeated skin infections, particularly abscesses or sterile abscesses on the trunk, arms, or legs, with or without needle marks (tracks).
3. Repeated requests for narcotic pain relievers without physical evidence of genesis of pain.
4. History of endocarditis.
5. Prior history of substance abuse.

D. Members with substance abuse problems can also be identified in the following ways:
1. Utilization Management (UM) department staff may refer Members to Case/ Disease Management for assessment and appropriate follow-up actions based on:
    a. Multiple referrals for 'pain control', abnormal liver tests, Hepatitis B or C sequelae, among others.
    b. Discharge planning of individuals hospitalized for substance abuse sequelae (i.e., endocarditis).
2. Identification may also occur through:
    a. Member Services referrals
    b. Grievances
    c. Alliance Pharmacy Staff identify Members using large numbers of narcotics and other potentially addictive medications.
    d. Alliance specialists seeing Members for conditions listed above and suspect substance abuse problems are responsible for informing the PCP and referring the Member to an appropriate program.

E. The PCP must discuss recommendations for treatment with the Member and:
1. Develop a treatment plan, and/or

2. Refer as appropriate to an acute detoxification program, inpatient treatment program, residential treatment program, or day treatment program through the Behavioral Health department, Alameda County Alcohol and Other Drugs Program or Medi-Cal FFS as appropriate.

F. PCPs are responsible for all necessary health care for Members with substance abuse problems. Depending on the specific substance abuse problem and the health status of the Member, services may include:

1. Limited or comprehensive physical exam with appropriate diagnostic testing to rule out associated medical conditions (e.g., hepatitis, endocarditis);
2. Limited mental status exam with appropriate treatment or referral for any actual or potential associated psychiatric conditions; and
3. Referral to specialty practitioners for evaluation as necessary (e.g., cardiology evaluation for valvular defects secondary to endocarditis).

G. The PCP has primary responsibility for referral to the appropriate substance abuse service with assistance from Alliance Behavioral Health/Utilization/Case Management departments. The PCP will:

1. Identify individuals requiring alcohol and or substance abuse treatment services and arrange for their referral to the Alcohol and Other Drugs Program, including outpatient heroin detoxification providers, for appropriate services.
2. Assist Members in locating available treatment service sites.
3. To the extent that treatment slots are not available in the California, Department of Alcohol and other Drugs Program (ADP) within the plan's Service Area, the Alliance will pursue placement outside the area.
4. Continue to ensure the provision of primary care and other services unrelated to the alcohol and substance abuse treatment. The Alliance will coordinate services between the primary care providers and the treatment programs.

H. With assistance from the Alliance, the PCP is responsible for relaying pertinent medical information to assist with the referral. Copies of medical records are sent to the substance abuse provider whenever necessary to facilitate the transition into a treatment program.

I. Members may also self-refer for substance abuse services to the appropriate AAH Behavioral Health network or Alameda County Alcohol and Other Drugs Program. The Alliance Member Services is available for assisting Members as needed at (510) 747-4567.

J. If a member presents at a general acute care facility for voluntary inpatient detoxification (VID) services but does not meet medical criteria for inpatient admission, the Alliance will coordinate with Alameda County Behavioral Health Care Services to refer the member to the necessary substance use disorder (SUD) treatment services. Substance Use Treatment and Referral Helpline is 1-844-682-7215 and is available 24 hours a day/7 day a week.

Group Care Requirements for Behavioral Health

A. The Alliance will comply with SB 855, which enacts CA Health and Safety Code §1374.72 and §1374.721 Mental Health and Substance Use Disorder Coverage.

B. In accordance with CA Health and Safety Code §1374.72, the Alliance will cover medically

necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM")~~.~~ . "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing he 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:

a. In accordance with the generally accepted standards of mental health and substance use disorder care.
b. Clinically appropriate in terms of type, frequency, extent, site, and duration.
c. 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.

C. The Alliance will not limit benefits or coverage for MH/SUD to short-term or acute treatment.
D. The Alliance will arrange coverage for out-of- network services for medically necessary treatment of a 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. The Alliance will continue to meet its obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.
E. The Alliance will not limit benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program.
F. In accordance with CA Health and Safety Code §1374.721:
    a. The Alliance will base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care.
    b. The Alliance will apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.
    c. The Alliance will sponsor a formal education program by nonprofit clinical specialty associations to educate all plan staff and delegates contracted to review claims, conduct utilization review, or make medical necessity determinations.
    d. The Alliance and its delegates will conduct interrater reliability testing and run reports to achieve an interrater reliability pass rate of at least 90 percent.
G. AAH understands and will comply with the requirement that contract provisions that reserve discretionary authority to the plan, or agent of the plan, to determine eligibility for benefits or coverage, interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with CA Health and Safety Code §1367.045 of this are void and unenforceable.

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

1. HED-006 SABIRT
2. BH-002 Behavioral Health Services
3. UM-002 Coordination of Care

RELATED WORFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2006, 1/1/2008, 10/28/2009, 8/30/2012, 4/14/2014, 01/10/2016, 02/07/2018, 04/15/2019, 5/21/2020, 3/18/2021, 5/20/2021, 6/28/2022, 6/20/2023

REFERENCES

1. DHCS Contract Exhibit A, Attachment 11, Provision 7
2. DHCS Contract, Amendment 17, Exhibit A, Attachments 10. Provision 8.E; 11. Provision 6. A and B; 12. Provision 3 and Attachment 21
3. MMCD Policy Letter No. 00-001 REV. MCMC Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program
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6. MMCD All Plan Letter 21-002 Implementation of Senate Bill 855, Mental Health and Substance Use Disorder Coverage

MONITORING

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POLICY AND PROCEDURE

Policy Number	BH-006
Policy Name	Coordination of Care – Substance Abuse
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Senior Director, BH Services
Lines of Business	All
Effective Date	11/21/2006
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	TBD

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4. Continue to ensure the provision of primary care and other services unrelated to the alcohol and substance abuse treatment. The Alliance will coordinate services between the primary care providers and the treatment programs.

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and §1374.721 Mental Health and Substance Use Disorder Coverage.

B. In accordance with CA Health and Safety Code §1374.72, the Alliance will cover medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing he 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:
    a. In accordance with the generally accepted standards of mental health and substance use disorder care.
    b. Clinically appropriate in terms of type, frequency, extent, site, and duration.
    c. 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.
C. The Alliance will not limit benefits or coverage for MH/SUD to short-term or acute treatment.
D. The Alliance will arrange coverage for out-of- network services for medically necessary treatment of a 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. The Alliance will continue to meet its obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.
E. The Alliance will not limit benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program.
F. In accordance with CA Health and Safety Code §1374.721:
    a. The Alliance will base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care.
    b. The Alliance will apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.
    c. The Alliance will sponsor a formal education program by nonprofit clinical specialty associations to educate all plan staff and delegates contracted to review claims, conduct utilization review, or make medical necessity determinations.
    d. The Alliance and its delegates will conduct interrater reliability testing and run reports to achieve an interrater reliability pass rate of at least 90 percent.
G. AAH understands and will comply with the requirement that contract provisions that reserve discretionary authority to the plan, or agent of the plan, to determine eligibility for benefits or coverage, interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with CA Health and Safety Code §1367.045 of this are void and unenforceable.

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

1. HED-006 SABIRT
2. BH-002 Behavioral Health Services
3. UM-002 Coordination of Care

RELATED WORFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2006, 1/1/2008, 10/28/2009, 8/30/2012, 4/14/2014, 01/10/2016, 02/07/2018, 04/15/2019, 5/21/2020, 3/18/2021, 5/20/2021, 6/28/2022, 6/20/2023

REFERENCES

1. DHCS Contract Exhibit A, Attachment 11, Provision 7
2. DHCS Contract, Amendment 17, Exhibit A, Attachments 10. Provision 8.E; 11. Provision 6. A and B; 12. Provision 3 and Attachment 21
3. MMCD Policy Letter No. 00-001 REV. MCMC Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program
4. MMCD All Plan Letter 13-021 Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services
5. MMCD All Plan Letter 13-023 Continuity of Care for Medi-Cal Beneficiaries who transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care
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MONITORING

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POLICY AND PROCEDURE

Policy Number	UM-018
Policy Name	Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens)
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	Medi-Cal
Effective Date	11/21/2006
Approval Date	TBD

POLICY STATEMENT

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens) for individuals 21 years of age or older: services are determined to be medically necessary when it is reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain are covered by AAH. For individuals under 21 years of age, services must meet the standards set forth in Section 1396d®(5) of Title 42 of the US Code., which includes: screening services, vision, dental and hearing services.

B. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services, defined as any service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of the AAH contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

C. A service does not need to cure a condition in order to be covered under EPSDT (Medi-Cal for Kids & Teens.) Services that maintain or improve the child's current health condition are also covered under EPSDT (Medi-Cal for Kids & Teens,) because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable or to make better." Additional services are provided if determined to be medically necessary for an individual child.

D. At AAH, medical necessity decisions are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not permitted. AAH does not impose service

limitations on any EPSDT (Medi-Cal for Kids & Teens,) covered service other than medical necessity. The determination of whether a service is medically necessary or a medical necessity for an individual child is made on a case-by-case basis, taking into account the particular needs of the child.

E. Pursuant to WIC Section 14059.5(b)(1), for individuals under 21 years of age, a service is considered "Medically Necessary" or a "Medical Necessity" if the service meets the standards set forth in federal Medicaid law for EPSDT (Title 42 of the USC Section 1396d(r)(5)). Therefore, an EPSDT (Medi-Cal for Kids & Teens,) covered service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions. AAH applies this definition when determining if a service is medically necessary or a medical necessity for any Member under the age of 21.

F. Coverage of preventive care and screenings must be conducted with evidence-informed, comprehensive guidelines as outlined by Bright Futures/the American Academy of Pediatrics (AAP) AAH uses the current AAP Bright Futures periodicity schedule and guidelines when delivering care to any Member under the age of 21, including but not limited to screening services, vision services, and hearing services. AAH provides all age-specific assessments and services required by the DHCS Contract and the AAP/Bright Futures periodicity schedule. AAH provides any medically necessary EPSDT (Medi-Cal for Kids & Teens,) services that exceed those recommended by AAP/Bright Futures.

G. AAH provides Members with appropriate referrals for diagnosis and treatment without delay. AAH is also responsible for ensuring Members under the age of 21 have timely access to all medically necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up. Services are initiated within timely access standards whether or not the services are Covered Services.

H. AAH provides case management and care coordination for all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services.

I. AAH exchanges necessary data for the provision of services as well as the coordination of non-covered services such as social support services.

J. The Alliance determines if a Medi-Cal Member requires EPSDT (Medi-Cal for Kids and Teens,) Case Management (CM) services through a participating local government agency or through an organization such as the Regional Center of the East Bay (RCEB).

K. AAH ensures the coverage of Targeted Case Management (TCM) services. The Alliance is responsible for assisting in the coordination of care for members who require Targeted Case Management (TCM) services to a Regional Center or local governmental health program. The Alliance is responsible for coordinating the member's health care with the TCM provider.

L. The Alliance will determine the medical necessity of diagnostic and treatment services recommended by the TCM provider and covered under the contract and will authorize approved services. If AAH determines that a Member is not eligible for TCM services, AAH will ensure that the Member's access to services is comparable to EPSDT (Medi-Cal for Kids & Teens,) TCM services.

M. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services except those services that

are specifically carved out of the DHCS Contract and not included in AAH's capitated rate. Carved-out services include, but are not limited to, California Children's Services (CCS) Program, dental services, Specialty Mental Health Services, and Substance Use Disorder Services.

N. The plan will provide and pay for EPSDT (Medi-Cal for Kids and Teens,) supplemental services, except for those services provided under California Children Services (CCS) and those targeted case management services (TCM) receiving funding through other mechanisms (dental, specialty mental health services and Substance Use Disorder Services)

O. The Alliance will provide access to medically necessary diagnostic and treatment services, including but not limited to BHT (Behavioral Health Treatment) services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist. AAH provides medically necessary Behavioral Health Treatment (BHT) services consistent with the requirements in APL 23-005, for eligible Members under the age of 21.

P. The Alliance will provide appointment scheduling assistance if needed and necessary non-emergency medical transportation (NMT) for services.

Q. The Alliance must inform members or their families about EPSDT, (Medi-Cal for Kids and Teens,) how to obtain services, transportation, health education, anticipatory guidance (members under 21) in the members' primary language.

PROCEDURE EPSDT (Medi-Cal for Kids and Teens,) Services

A. Member needs for EPSDT (Medi-Cal for Kids and Teens,) Services are determined primarily through initial and periodic health assessments by the Member's PCP in accordance with Child Health and Disability Prevention Program (CHDP) required services. The need for EPSDT (Medi-Cal for Kids and Teens,) supplemental services may also be identified by the Member, the Member's parent or other family members, through a Member's encounter with a health care practitioner, or from the Utilization Management staff while reviewing prior authorization requests.

B. If a PCP, specialist Alliance case manager identifies the need for a health care service for a Member under age 21 that is not covered by the Alliance, the service may be available as an EPSDT (Medi-Cal for Kids and Teens,) service. The PCP or specialist must request the services from the Alliance and document the rationale for the request in the medical record. Alliance Utilization Management (UM) will assess if the service is medically necessary, regardless of whether or not it is a defined benefit.

C. Examples of EPSDT (Medi-Cal for Kids and Teens,) Supplemental Services are: cochlear implants, EPSDT (Medi-Cal for Kids and Teens,) CM services and EPSDT (Medi-Cal for Kids and Teens,) supplemental nursing services. EPSDT (Medi-Cal for Kids and Teens,) services also include additional services beyond those otherwise limited to two-per-month with Medi- Cal. These services include psychology, chiropractic, occupational therapy, speech therapy, audiology, and acupuncture.

EPSDT (Medi-Cal for Kids and Teens,) Nursing Services

A. EPSDT (Medi-Cal for Kids and Teens,) nursing services include hourly or shift nursing services provided by or under the supervision of licensed, skilled nursing personnel in a Member's residence or in a specialized foster care home.

EPSDT (Medi-Cal for Kids and Teens,) Case Management (CM) Services

A. Alliance CM is required to provide all necessary CM services for Members accessing EPSDT (Medi-Cal for Kids and Teens,) supplemental services including at a minimum:
    1. Arranging for all approved services including out-of-network practitioners as needed;
    2. Coordination of care between all practitioners (PCPs, specialists, other EPSDT (Medi-Cal for Kids and Teens,) providers);
    3. Transferring medical information as necessary between practitioners; and
    4. Developing a specific care plan for the Member as needed.

B. Alliance UM/CM staff are responsible for assessing a Member's need for EPSDT (Medi-Cal for Kids and Teens,) CM services. The criteria to be used in determining the necessity for EPSDT (Medi-Cal for Kids and Teens,) CM services include whether or not:
    1. The Member has a complicated medical condition and/or behavioral health condition resulting in significant impairment.
    2. The Member has one or more environmental risk factors (primary care giver under 18 years or primary care giver has a disability).
    3. Any environmental stressors would compromise the primary care giver's ability to assist the Member in gaining access to necessary medical, social, educational, or other services.

C. Alliance CM must determine if the Member is eligible or is already receiving targeted CM through a participating local governmental agency or through an entity or organization including but not limited to the following:
    1. RCEB
    2. Children's Hospital
    3. City of Fremont – Linkages
    4. City of Fremont - FFRC
    5. City of Oakland
    6. Covenant House California
    7. Public Health Department
    8. Roots Community Health Center
    9. Probation Department
    10. Tiburcio Vasquez Health Center

    If the Member receives targeted CM through one of these entities, the Alliance CM will coordinate care with the case manager from the agency and coordinate determination of medical necessity of diagnostic and treatment services covered by the Alliance. The Alliance CM will share minimum necessary information with the entity to ensure the specific needs of the member at met, through secure resources (for example, but not limited to, secure email or sFTP shared site).

D. Specialized EPSDT (Medi-Cal for Kids and Teens,) CM services may be provided by a Targeted Case Management (TCM) entity (e.g., RCEB), a child protection agency, other agencies or entities serving children, or an individual practitioner whom the Alliance finds qualified by education, training, or experience to provide specialized CM services. Alliance CM is responsible for arranging the necessary case management for Members.

E. If a Member receives TCM or specialized EPSDT (Medi-Cal for Kids and Teens,) CM services, Alliance CM is required to coordinate those services with the PCP and/or specialist practitioner. This includes coordination with RCEB CM as well as any other agencies' CM staff providing the services.

F. EPSDT (Medi-Cal for Kids and Teens,) CM services may be provided by the Alliance, RCEB, Child Protective Services, or the Department of Mental Health as needed.

Targeted Case Management Services

A. The Alliance and PCPs are responsible for determining whether members require Targeted Case Management (TCM) services, and for referring members who are eligible for TCM services to RCEB or the local government health program as appropriate for the provision of TCM services.

    1. The Alliance maintains a Memorandum of Understanding (MOU) with Regional Center of the East Bay (RCEB) and Alameda County for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of targeted case management for Medi-Cal members enrolled in the Alliance.

B. TCM services provided by RCEB include at least one of the following, as described in Title 22, CCR, Section 51351:

    1. A documented assessment identifying the member's needs;
    2. The development of a comprehensive, written, individual service plan, based upon the assessment;
    3. The implementation of the service plan, which includes linkage and consultation with and referral to providers of service;
    4. Assistance with accessing the services identified in the service plan;
    5. Crisis assistance planning to coordinate and arrange immediate services or treatment needed in those situations that appear to be emergent in nature; and
    6. Periodic review of the member's progress toward achieving the service outcomes identified in the service plan;

C. If a member is receiving TCM services as specified in Title 22, CCR, Section 51351, the Alliance is responsible for coordinating the member's health care with the TCM provider and for providing Care Coordination for all Medically Necessary Covered Services identified by the TCM Providers in their Member care plans, including referrals and Prior Authorization for Out-of-Network medical services.

    1. This coordination continues until the TCM provider notifies the Alliance that TCM services are no longer needed for the member.
    2. The Alliance is responsible for coordinating the provision of services, including TCM, with the other entities to ensure that the Alliance and other entities are not providing duplicative services.
        - This process includes but is not limited to: contacting the other entity, assessing for services provided by the other entity, and communication

with the other entity regarding the delegation of services needed by the member.

D. The Alliance designates an RCEB liaison responsible for coordinating TCM services with RCEB and local government agencies, if needed.

1. Responsibilities of the liaison include, but not limited to: sharing appropriate member provider(s) information, PCP information, care manager assignment with RCEB and local government agencies as needed, and resolving all related operational issues

- The Alliance notifies member's PCP and/or care managers when members are receiving TCM services and provides them with appropriate local governmental agency contact information.

E. For members under the age of twenty-one (21), not accepted by RCEB for TCM services, the Alliance ensures that they have access to comparable EPSDT (Medi-Cal for Kids and Teens,) TCM services.

Behavioral Health Services

A. The provision of EPSDT (Medi-Cal for Kids and Teens,) services for members under 21 years of age, which includes medically necessary, evidence-based BHT services that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, will become the responsibility of the Alliance:

1. Effective on the date of the member's transition from the RC
2. For new members, upon MCP enrollment

B. Criteria for BHT Services:

1. Be under 21 years of age.
2. Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.
3. Be medically stable.
4. Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

The Alliance is responsible for coordinating the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services

C. BHT Covered Services:

1. Medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist.
2. Delivered in accordance with the member's MCP-approved behavioral treatment plan.
3. Provided by California State Plan approved providers as defined in SPA 14-026.9 4) Provided and supervised according to an MCP-approved behavioral treatment plan developed by a BHT service provider credentialed as specified in SPA 14-026 ("BHT Service Provider").

D. BHT services are provided under a behavioral treatment plan:

1. The BHT treatment plan must have measurable goals over a specific timeline for the specific member
2. The BHT treatment plan must be developed by a BHT Service Provider.
3. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider.
4. The behavioral treatment plan may be modified if medically necessary.
5. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

E. Services that do not meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:
    1. Services rendered when continued clinical benefit is not expected.
    2. Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
    3. Treatment whose sole purpose is vocationally- or recreationally-based.
    4. Custodial care. For purposes of BHT services, custodial care:
        a. Is provided primarily for maintaining the member's or anyone else's safety.
        b. Could be provided by persons without professional skills or training.
    5. Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
    6. Services rendered by a parent, legal guardian, or legally responsible person.
    7. Services that are not evidence-based behavioral intervention practices.

F. The approved behavioral treatment plan must meet the following criteria:

    1. Be developed by a BHT Service Provider for the specific member being treated.
    2. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
    3. Be person-centered and based upon individualized, measurable goals and objectives over a specific timeline.
    4. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
    5. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
    6. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
    7. Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
    8. Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
    9. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation

needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.

10. Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
11. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
12. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community.
13. Include an exit plan/criteria.

G. Continuity of care:

1. The Alliance must automatically initiate the continuity of care process prior to the member's transition to the MCP for BHT services.
2. At least 45 days prior to the transition date, DHCS will provide the Alliance with a list of members for whom the responsibility for BHT services will transition from RCs to the Alliance, as well as member-specific utilization data. The utilization data file will include information about services and rendering providers recently accessed by members.
3. The Alliance will utilize the data and treatment information provided by DHCS, the RC, or the rendering provider to determine BHT service needs and associated rendering providers. This information should be used to determine if the current BHT provider is in the MCP's network and if a continuity of care arrangement is necessary.
4. The Alliance must make a good faith effort to proactively contact the provider to begin the continuity of care process.
5. The Alliance must offer members continued access to an out-of-network provider of BHT services (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL 18-008, if all of the following conditions are met:
    a. The member has an existing relationship with a qualified provider of BHT services. An existing relationship means the member has seen the provider at least one time during the six months prior to either the transition of services from the RC to the Alliance or the date of the member's initial enrollment in the Alliance if enrollment occurred on or after July 1, 2018.
    b. The provider and the Alliance can agree to a rate, with the minimum rate offered by the Alliance being the established Medi-Cal fee-for-service (FFS) rate for the applicable BHT service.
    c. The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the Alliance's network.
    d. The provider is a California State Plan approved provider.

e. The provider supplies the Alliance with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and regulations.

6. If a member has an existing relationship, as defined above, with an in-network BHT service provider, the Alliance must assign the member to that provider to continue BHT services.
7. BHT services should not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by the Alliance, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network Alliance provider.
8. If a continuity of care agreement cannot be reached with the RC provider by the date of transition to the Alliance, the Alliance must appropriately transition the member to a new, in-network BHT service provider and ensure that neither a gap nor a change in services occurs until such time as the Alliance approves a new assessment and behavioral treatment plan from an in-network BHT service provider.

OUTBOUND CALL CAMPAIGN:

To inform members who are transitioning from RCs of their automatic continuity of care rights, the Alliance must conduct an Outbound Call Campaign, as described below.

A. Call the member (or his/her parent/guardian) after 60-day member informing notices are mailed and prior to the date of transition.
B. Make five call attempts to reach the member (or his/her parent/guardian).
C. Inform the member of the transition and the continuity of care process.
D. Not call members who have explicitly requested not to be called.

REPORTING AND MONITORING:

The Alliance will report metrics to DHCS related to the requirements in a manner determined by DHCS.

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

EPSDT (Medi-Cal for Kids and Teens,) Supplemental Services: Services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or other condition that must be provided to an Alliance member under 21 years of age.

AFFECTED DEPARTMENTS/PARTIES

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

DHCS Contract Exhibit A, Attachment 1, Provision 3 and 11
Title 22, CCR, Sections 51184, 51303, 51340, 51340.1, and 51351
Welfare and Institutions Code, CCR, Section 14132.44
APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21

REVISION HISTORY

1/1/2008, 10/28/2009, 4/1/2011, 8/30/2012, 01/10/2016, 12/15/2016, 7/19/2018, 8/3/2018, 09/06/2018, 11/21/2019, 7/31/20, 9/17/2020, 03/22/2022

REFERENCES

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-018
Policy Name	Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens)
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	Medi-Cal
Effective Date	11/21/2006
Approval Date	TBD

POLICY STATEMENT

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens) for individuals 21 years of age or older: services are determined to be medically necessary when it is reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain are covered by AAH. For individuals under 21 years of age, services must meet the standards set forth in Section 1396d®(5) of Title 42 of the US Code., which includes: screening services, vision, dental and hearing services.

B. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services, defined as any service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of the AAH contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

C. A service does not need to cure a condition in order to be covered under EPSDT (Medi-Cal for Kids & Teens.) Services that maintain or improve the child's current health condition are also covered under EPSDT (Medi-Cal for Kids & Teens,) because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable or to make better." Additional services are provided if determined to be medically necessary for an individual child.

D. At AAH, medical necessity decisions are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not permitted. AAH does not impose service

limitations on any EPSDT (Medi-Cal for Kids & Teens,) covered service other than medical necessity. The determination of whether a service is medically necessary or a medical necessity for an individual child is made on a case-by-case basis, taking into account the particular needs of the child.

E. Pursuant to WIC Section 14059.5(b)(1), for individuals under 21 years of age, a service is considered "Medically Necessary" or a "Medical Necessity" if the service meets the standards set forth in federal Medicaid law for EPSDT (Title 42 of the USC Section 1396d(r)(5)). Therefore, an EPSDT (Medi-Cal for Kids & Teens,) covered service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions. AAH applies this definition when determining if a service is medically necessary or a medical necessity for any Member under the age of 21.

F. Coverage of preventive care and screenings must be conducted with evidence-informed, comprehensive guidelines as outlined by Bright Futures/the American Academy of Pediatrics (AAP) AAH uses the current AAP Bright Futures periodicity schedule and guidelines when delivering care to any Member under the age of 21, including but not limited to screening services, vision services, and hearing services. AAH provides all age-specific assessments and services required by the DHCS Contract and the AAP/Bright Futures periodicity schedule. AAH provides any medically necessary EPSDT (Medi-Cal for Kids & Teens,) services that exceed those recommended by AAP/Bright Futures.

G. AAH provides Members with appropriate referrals for diagnosis and treatment without delay. AAH is also responsible for ensuring Members under the age of 21 have timely access to all medically necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up. Services are initiated within timely access standards whether or not the services are Covered Services.

H. AAH provides case management and care coordination for all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services.

I. AAH exchanges necessary data for the provision of services as well as the coordination of non-covered services such as social support services.

J. The Alliance determines if a Medi-Cal Member requires EPSDT (Medi-Cal for Kids and Teens,) Case Management (CM) services through a participating local government agency or through an organization such as the Regional Center of the East Bay (RCEB).

K. AAH ensures the coverage of Targeted Case Management (TCM) services. The Alliance is responsible for assisting in the coordination of care for members who require Targeted Case Management (TCM) services to a Regional Center or local governmental health program. The Alliance is responsible for coordinating the member's health care with the TCM provider.

L. The Alliance will determine the medical necessity of diagnostic and treatment services recommended by the TCM provider and covered under the contract and will authorize approved services. If AAH determines that a Member is not eligible for TCM services, AAH will ensure that the Member's access to services is comparable to EPSDT (Medi-Cal for Kids & Teens,) TCM services.

M. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services except those services that

are specifically carved out of the DHCS Contract and not included in AAH's capitated rate. Carved-out services include, but are not limited to, California Children's Services (CCS) Program, dental services, Specialty Mental Health Services, and Substance Use Disorder Services.

N. The plan will provide and pay for EPSDT (Medi-Cal for Kids and Teens,) supplemental services, except for those services provided under California Children Services (CCS) and those targeted case management services (TCM) receiving funding through other mechanisms (dental, specialty mental health services and Substance Use Disorder Services)

O. The Alliance will provide access to medically necessary diagnostic and treatment services, including but not limited to BHT (Behavioral Health Treatment) services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist. AAH provides medically necessary Behavioral Health Treatment (BHT) services consistent with the requirements in APL 23-005, for eligible Members under the age of 21.

P. The Alliance will provide appointment scheduling assistance if needed and necessary non-emergency medical transportation (NMT) for services.

Q. The Alliance must inform members or their families about EPSDT, (Medi-Cal for Kids and Teens,) how to obtain services, transportation, health education, anticipatory guidance (members under 21) in the members' primary language.

PROCEDURE EPSDT (Medi-Cal for Kids and Teens,) Services

A. Member needs for EPSDT (Medi-Cal for Kids and Teens,) Services are determined primarily through initial and periodic health assessments by the Member's PCP in accordance with Child Health and Disability Prevention Program (CHDP) required services. The need for EPSDT (Medi-Cal for Kids and Teens,) supplemental services may also be identified by the Member, the Member's parent or other family members, through a Member's encounter with a health care practitioner, or from the Utilization Management staff while reviewing prior authorization requests.

B. If a PCP, specialist Alliance case manager identifies the need for a health care service for a Member under age 21 that is not covered by the Alliance, the service may be available as an EPSDT (Medi-Cal for Kids and Teens,) service. The PCP or specialist must request the services from the Alliance and document the rationale for the request in the medical record. Alliance Utilization Management (UM) will assess if the service is medically necessary, regardless of whether or not it is a defined benefit.

C. Examples of EPSDT (Medi-Cal for Kids and Teens,) Supplemental Services are: cochlear implants, EPSDT (Medi-Cal for Kids and Teens,) CM services and EPSDT (Medi-Cal for Kids and Teens,) supplemental nursing services. EPSDT (Medi-Cal for Kids and Teens,) services also include additional services beyond those otherwise limited to two-per-month with Medi- Cal. These services include psychology, chiropractic, occupational therapy, speech therapy, audiology, and acupuncture.

EPSDT (Medi-Cal for Kids and Teens,) Nursing Services

A. EPSDT (Medi-Cal for Kids and Teens,) nursing services include hourly or shift nursing services provided by or under the supervision of licensed, skilled nursing personnel in a Member's residence or in a specialized foster care home.

EPSDT (Medi-Cal for Kids and Teens,) Case Management (CM) Services

A. Alliance CM is required to provide all necessary CM services for Members accessing EPSDT (Medi-Cal for Kids and Teens,) supplemental services including at a minimum:
    1. Arranging for all approved services including out-of-network practitioners as needed;
    2. Coordination of care between all practitioners (PCPs, specialists, other EPSDT (Medi-Cal for Kids and Teens,) providers);
    3. Transferring medical information as necessary between practitioners; and
    4. Developing a specific care plan for the Member as needed.

B. Alliance UM/CM staff are responsible for assessing a Member's need for EPSDT (Medi-Cal for Kids and Teens,) CM services. The criteria to be used in determining the necessity for EPSDT (Medi-Cal for Kids and Teens,) CM services include whether or not:
    1. The Member has a complicated medical condition and/or behavioral health condition resulting in significant impairment.
    2. The Member has one or more environmental risk factors (primary care giver under 18 years or primary care giver has a disability).
    3. Any environmental stressors would compromise the primary care giver's ability to assist the Member in gaining access to necessary medical, social, educational, or other services.

C. Alliance CM must determine if the Member is eligible or is already receiving targeted CM through a participating local governmental agency or through an entity or organization ~~such as~~including but not limited to the following:
    1. RCEB~~.~~
    2. Children's Hospital
    3. City of Fremont – Linkages
    4. City of Fremont - FFRC
    5. City of Oakland
    6. Covenant House California
    7. Public Health Department
    8. Roots Community Health Center
    9. Probation Department
    10. Tiburcio Vasquez Health Center~~-~~

    ~~C.~~ If the Member receives targeted CM through one of these entities, the Alliance CM will coordinate care with the case manager from the agency and coordinate determination of medical necessity of diagnostic and treatment services covered by the Alliance. The Alliance CM will ~~also~~ share minimum necessary information with the entity to ensure the specific needs of the member at met, ~~receives all necessary services~~ through secure resources (for example, but not limited to, secure email or sFTP shared site).

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D. Specialized EPSDT (Medi-Cal for Kids and Teens,) CM services may be provided by a Targeted Case Management (TCM) entity (e.g., RCEB), a child protection agency, other agencies or entities serving children, or an individual practitioner whom the Alliance finds qualified by education, training, or experience to provide specialized CM services. Alliance CM is responsible for arranging the necessary case management for Members.

E. If a Member receives TCM or specialized EPSDT (Medi-Cal for Kids and Teens,) CM services, Alliance CM is required to coordinate those services with the PCP and/or specialist practitioner. This includes coordination with RCEB CM as well as any other agencies' CM staff providing the services.

F. EPSDT (Medi-Cal for Kids and Teens,) CM services may be provided by the Alliance, RCEB, Child Protective Services, or the Department of Mental Health as needed.

Targeted Case Management Services

A. The Alliance and PCPs are responsible for determining whether members require Targeted Case Management (TCM) services, and for referring members who are eligible for TCM services to RCEB or the local government health program as appropriate for the provision of TCM services.

   1. The Alliance maintains a Memorandum of Understanding (MOU) with Regional Center of the East Bay (RCEB) and Alameda County for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of targeted case management for Medi-Cal members enrolled in the Alliance.

B. TCM services provided by RCEB include at least one of the following, as described in Title 22, CCR, Section 51351:

   1. A documented assessment identifying the member's needs;
   2. The development of a comprehensive, written, individual service plan, based upon the assessment;
   3. The implementation of the service plan, which includes linkage and consultation with and referral to providers of service;
   4. Assistance with accessing the services identified in the service plan;
   5. Crisis assistance planning to coordinate and arrange immediate services or treatment needed in those situations that appear to be emergent in nature; and
   6. Periodic review of the member's progress toward achieving the service outcomes identified in the service plan;

C. If a member is receiving TCM services as specified in Title 22, CCR, Section 51351, the Alliance is responsible for coordinating the member's health care with the TCM provider and for providing Care Coordination for all Medically Necessary Covered Services identified by the TCM Providers in their Member care plans, including referrals and Prior Authorization for Out-of-Network medical services.

   1. This coordination continues until the TCM provider notifies the Alliance that TCM services are no longer needed for the member.
   2. The Alliance is responsible for coordinating the provision of services, including TCM, with the other entities to ensure that the Alliance and other entities are not providing duplicative services.

      ~~2.~~• This process includes but is not limited to: contacting the other entity, assessing for services provided by the other entity, and communication

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with the other entity regarding the delegation of services needed by the member.

D. The Alliance designates an RCEB liaison responsible for coordinating TCM services with RCEB and local government agencies, if needed.

1. Responsibilities of the liaison include, but not limited to: sharing appropriate member provider(s) information, PCP information, care manager assignment with RCEB and local government agencies as needed, and resolving all related operational issues

- The Alliance notifies member's PCP and/or care managers when members are receiving TCM services and provides them with appropriate local governmental agency contact information.

E. For members under the age of twenty-one (21), not accepted by RCEB for TCM services, the Alliance ensures that they have access to comparable EPSDT (Medi-Cal for Kids and Teens,) TCM services.

Behavioral Health Services

A. The provision of EPSDT (Medi-Cal for Kids and Teens,) services for members under 21 years of age, which includes medically necessary, evidence-based BHT services that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, will become the responsibility of the Alliance:

1. Effective on the date of the member's transition from the RC
2. For new members, upon MCP enrollment

B. Criteria for BHT Services:

1. Be under 21 years of age.
2. Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.
3. Be medically stable.
4. Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

The Alliance is responsible for coordinating the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services

C. BHT Covered Services:

1. Medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist.
2. Delivered in accordance with the member's MCP-approved behavioral treatment plan.
3. Provided by California State Plan approved providers as defined in SPA 14-026.9 4) Provided and supervised according to an MCP-approved behavioral treatment plan developed by a BHT service provider credentialed as specified in SPA 14-026 ("BHT Service Provider").

D. BHT services are provided under a behavioral treatment plan:

1. The BHT treatment plan must have measurable goals over a specific timeline for the specific member
2. The BHT treatment plan must be developed by a BHT Service Provider.
3. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider.
4. The behavioral treatment plan may be modified if medically necessary.
5. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

E. Services that do not meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:
    1. Services rendered when continued clinical benefit is not expected.
    2. Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
    3. Treatment whose sole purpose is vocationally- or recreationally-based.
    4. Custodial care. For purposes of BHT services, custodial care:
        a. Is provided primarily for maintaining the member's or anyone else's safety.
        b. Could be provided by persons without professional skills or training.
    5. Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
    6. Services rendered by a parent, legal guardian, or legally responsible person.
    7. Services that are not evidence-based behavioral intervention practices.

F. The approved behavioral treatment plan must meet the following criteria:

    1. Be developed by a BHT Service Provider for the specific member being treated.
    2. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
    3. Be person-centered and based upon individualized, measurable goals and objectives over a specific timeline.
    4. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
    5. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
    6. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
    7. Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
    8. Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
    9. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation

needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.

10. Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
11. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
12. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community.
13. Include an exit plan/criteria.

G. Continuity of care:

1. The Alliance must automatically initiate the continuity of care process prior to the member's transition to the MCP for BHT services.
2. At least 45 days prior to the transition date, DHCS will provide the Alliance with a list of members for whom the responsibility for BHT services will transition from RCs to the Alliance, as well as member-specific utilization data. The utilization data file will include information about services and rendering providers recently accessed by members.
3. The Alliance will utilize the data and treatment information provided by DHCS, the RC, or the rendering provider to determine BHT service needs and associated rendering providers. This information should be used to determine if the current BHT provider is in the MCP's network and if a continuity of care arrangement is necessary.
4. The Alliance must make a good faith effort to proactively contact the provider to begin the continuity of care process.
5. The Alliance must offer members continued access to an out-of-network provider of BHT services (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL 18-008, if all of the following conditions are met:
    a. The member has an existing relationship with a qualified provider of BHT services. An existing relationship means the member has seen the provider at least one time during the six months prior to either the transition of services from the RC to the Alliance or the date of the member's initial enrollment in the Alliance if enrollment occurred on or after July 1, 2018.
    b. The provider and the Alliance can agree to a rate, with the minimum rate offered by the Alliance being the established Medi-Cal fee-for-service (FFS) rate for the applicable BHT service.
    c. The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the Alliance's network.
    d. The provider is a California State Plan approved provider.

e. The provider supplies the Alliance with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and regulations.

6. If a member has an existing relationship, as defined above, with an in-network BHT service provider, the Alliance must assign the member to that provider to continue BHT services.
7. BHT services should not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by the Alliance, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network Alliance provider.
8. If a continuity of care agreement cannot be reached with the RC provider by the date of transition to the Alliance, the Alliance must appropriately transition the member to a new, in-network BHT service provider and ensure that neither a gap nor a change in services occurs until such time as the Alliance approves a new assessment and behavioral treatment plan from an in-network BHT service provider.

OUTBOUND CALL CAMPAIGN:

To inform members who are transitioning from RCs of their automatic continuity of care rights, the Alliance must conduct an Outbound Call Campaign, as described below.

A. Call the member (or his/her parent/guardian) after 60-day member informing notices are mailed and prior to the date of transition.
B. Make five call attempts to reach the member (or his/her parent/guardian).
C. Inform the member of the transition and the continuity of care process.
D. Not call members who have explicitly requested not to be called.

REPORTING AND MONITORING:

The Alliance will report metrics to DHCS related to the requirements in a manner determined by DHCS.

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

EPSDT (Medi-Cal for Kids and Teens,) Supplemental Services: Services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or other condition that must be provided to an Alliance member under 21 years of age.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

DHCS Contract Exhibit A, Attachment 1, Provision 3 and 11
Title 22, CCR, Sections 51184, 51303, 51340, 51340.1, and 51351
Welfare and Institutions Code, CCR, Section 14132.44
APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21

REVISION HISTORY

1/1/2008, 10/28/2009, 4/1/2011, 8/30/2012, 01/10/2016, 12/15/2016, 7/19/2018, 8/3/2018, 09/06/2018, 11/21/2019, 7/31/20, 9/17/2020, 03/22/2022

REFERENCES

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.

ALAMEDA Alliance FOR HEALTH
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POLICY AND PROCEDURE

Policy Number	UM-024
Policy Name	Care Coordination – Dental Services
Department Name	Medical Services
Department Chief	Chief Medical Officer
Policy Owner	Senior Director, Health Care Services
Line of Business	Medi-Cal
Effective Date	10/27/2005
Approval Revised Date	TBD

POLICY STATEMENT

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 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 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.

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.

PROCEDURE

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) 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.
   b) PCPs shall provide routine preventive dental advice regarding mouth care including daily tooth brushing, flossing, and the use of fluoride toothpaste.
   c) PCPs shall continue to observe the Member for dental 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.
      i. 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) 423-0507
      ii. PCPs shall document the results of the dental screening exam in the medical record.
   d) 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 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.
   a) 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.
   b) 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.
   c) 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.
   d) 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.
   e) The Alliance must coordinate all necessary non-anesthesia services provided to a member.
   f) 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.

g) 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)
   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 medical needs of the member.
   c) If the above is met, then 1 of the following must also be present:
      i. Inability to immobilize a member or is not feasible based on the medical needs of the member
      ii. Member requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or minimal sedation
      iii. The member has acute situational anxiety due to immature cognitive functioning
      iv. 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) Delegation Oversight

   a) 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-0042 for monitoring of delegation oversight.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

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, 1/24/2023

REFERENCES

1. DHCS Contract Exhibit A, Attach 11, Provision 15
2. CA Health and Safety Code, Section 1367.71
3. DHCSMMCD Policy Letter 13-002 Dental Services – General Anesthesia Coverage
4. DHCS MMCD All Plan Letter 07-008 Topical Fluoride Varnish
5. DHCSMMCD All Plan Letter 23-028 Dental Services – Intravenous Moderate Sedation and Deep Sedation/General Anesthesia Coverage
    - Attachment A: Policy for Intravenous Moderate Sedation and Deep Sedation/General Anesthesia
    - Attachment B: Intravenous Moderate Sedation and Deep Sedation/General Anesthesia: Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios
6. Table 21.4: CHDP/EPSDT Periodicity Schedule for Dental Referral By Age, Revised 2/20/2019
7. Table: Bright Futures/American Academy of Pediatrics Recommendations for Preventative Pediatric Health Care, Updated July 2022

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	Medical Services
Department Chief	Chief Medical Officer
Policy Owner	Senior Director, Health Care Services
Line of Business	Medi-Cal
Effective Date	10/27/2005
Approval Revised Date	~~02/21/2023~~ TBD

POLICY STATEMENT

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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.

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   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 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.

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.

PROCEDURE

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   b) 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.
   c) 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 ~~12-012~~ 23-028 requirement.
   d) 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 ~~15-012~~ 23-028 requirements.
   e) The Alliance must coordinate all necessary non-anesthesia services provided to a member.
   f) 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

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g) 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)
   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 medical needs of the member.
   c) If the above is met, then 1 of the following must also be present:
      i. Inability to immobilize a member or is not feasible based on the medical needs of the member
      ii. Member requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or minimal sedation
      iii. The member has acute situational anxiety due to immature cognitive functioning
      iv. 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.

~~3)~~ 5) ~~5.~~ Delegation Oversight

a) 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-0042 for monitoring of delegation oversight.

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AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

UM-033 Topical Fluoride Varnish
UM-001 Utilization Management Program
Provider Manual

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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, 1/24/2023

REFERENCES

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2. CA Health and Safety Code, Section 1367.71
3. DHCSMMCD Policy Letter 13-002 Dental Services – General Anesthesia Coverage
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    - Attachment A: Policy for Intravenous Moderate Sedation and Deep Sedation/General Anesthesia
    - Attachment B: Intravenous Moderate Sedation and Deep Sedation/General Anesthesia: Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios
6. Table 21.4: CHDP/EPSDT Periodicity Schedule for Dental Referral By Age, Revised 2/20/2019
7. Table: Bright Futures/American Academy of Pediatrics Recommendations for Preventative Pediatric Health Care, Updated July 2022

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-032
Policy Name	Therapeutic Enteral Formulas
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	Medi-Cal/ Group Care (IHSS)
Effective Date	1/1/2008
Approval Date	TBD

POLICY STATEMENT

Enteral nutrition products may be covered upon authorization when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food *(California Code of Regulations* [CCR], Title 22, Section 51313.3).

The Department of Health Care Services' (DHCS) Medi-Cal pharmacy benefit limits the enteral nutrition product benefit to those products administered through a gastric, nasogastric, or jejunostomy feeding tube, for adults 22 years of age or older, with the exception of products consumer orally for inborn error of metabolism, and products consumed orally for intestinal malabsorption diagnoses. Beneficiaries 21 years of age and younger are exempt from the enteral nutrition product benefit tube feeding limitation.

Enteral nutrition products are reimbursable through Medi-Cal Rx as a pharmacy-billed item for products administered orally or through a tube. Parenteral services will continue under the medical benefit and be managed by the Alliance or Delegates. Services provided under MediCal Rx are described in the *Enteral Nutrition Products* sections of the Medi-Cal Allied Health Provider Manual.

Unless otherwise indicated, the majority of activities will be applicable to Medi-Cal only.

The Alliance will seek opportunities to work collaboratively with local county and community agencies through the Memorandum of Understanding (MOU) process to evaluate and meet the needs of these high-risk health plan members.

PROCEDURE

A. Authorization of Therapeutic Enteral Formulas

1. A prescription by a licensed provider is required for medical authorization of enteral nutrition products.
2. Authorization procedures and review for approval of therapeutic enteral formulas will be supervised by qualified healthcare professionals and denials will be reviewed by a qualified physician.
3. The enteral nutrition product requested on an authorization must be on the *List of Enteral Nutrition Products as defined by the Department of Health Services (DHCS)* and the member must meet the medical criteria for the specific product category and, if applicable, product-specific criteria.
    a. Prior Authorization requests for Enteral Nutrition Formula will be made to DHCS utilizing the DHCS 6505 Medi-Cal Rx Enteral Nutrition Prior Authorization Request Form.
    b. Requests for Enteral Nutrition Supplies including syringes, pumps, tubing, etc. will be made directly to AAH using the AAH Prior Authorization Request Form.
    c. For Group Care (IHSS) Line of Business the Alliance will provide all enterenal nutrition formula and enteral nutrition supplies.
4. Determining medical necessity of enteral nutrition products for medical conditions requires a thorough history, physician examination, nutrition assessment, laboratory testing, feeding observation, when applicable, and evaluation of a member's behavior and home environment.
5. Decisions and appeals regarding therapeutic enteral formula will be performed in a timely manner by Medi-Cal Rx.
6. Services are based on the sensitivity of medical conditions and rendered as*:*
    a. Expedited requests: within 72 hours for services if a provider or a plan determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
    b. Non-emergency requests: within five (5) working days when proposed treatment meets objective medical criteria, and is not contraindicated.
7. Verbal or written notification will be provided to any provider requesting a service by prior authorization that is denied, approved, or modified in an amount, duration or scope that is less than that requested by the provider by Medi-Cal Rx.
8. Members will be notified in writing about denied, deferred, or modified services by Medi-Cal Rx.

9. Both providers and members will be notified about the appeals procedure by Medi-Cal Rx.

B. Informing Providers and Members

1. The Alliance will use the Provider Manual and Provider Newsletters to inform providers about:
   a. Prescription and authorization procedures for provision of therapeutic enteral formulas
   b. Timeliness standards
   c. Requirements for periodic physical assessment and follow-up evaluation
   d. Local referral resources
   e. Formulary list of approved therapeutic formulas, and processes for approval of newly marketed therapeutic enteral formulas.
2. The Alliance will inform members about the processes and procedures for provision of medically necessary therapeutic enteral formulas via:
   a. Member EOC
   b. Member Newsletters

C. Parenteral Nutrition requests will follow the prior authorization process outlined in UM-057 Authorization Service Requests

D. 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

Therapeutic "medical" food is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation (21 U.S.C. 360ee(b)(3)). Parenteral Nutrition are defined as solutions, suspensions, emulsions for injection or infusion, powders for injection or infusion, gels for injection and implants. They are sterile preparations intended to be administrated directly into the systemic circulation.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
UM-057 Authorization Service Requests

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

10/28/2009, 7/20/2012, 9/6/2012, 10/2/2012, 4/21/2014, 6/25/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 11/23/2021, 1/24/2024

REFERENCES

Medical Services Workflow- Therapeutic Formula Referrals

MMCD Policy Letter 14-003 Enteral Nutrition Products
Medi-Cal Provider Manual - Allied Health, March 2014, Enteral Nutrition Products:

- An Overview
- Elemental and Semi-Elemental
- Metabolic
- Specialized
- Specialty Infant
- Standard

Title 22 §51313.3
Welfare & Institutions Code § 14132.86, 14105.8, 14105.395
Title 42 CFR § 431.63(c)
DHCS Policy – Enteral Nutrition Products, December 2020
DHCS List of Enteral Nutrition Products
DHCS 6505 Medi-Cal Rx Enteral Nutrition Prior Authorization Request Form

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-032
Policy Name	Therapeutic Enteral Formulas
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	~~Medical Director~~Director Utilization Management
Lines of Business	Medi-Cal/ Group Care (IHSS)
Effective Date	1/1/2008
Approval Date	TBD~~02/21/2023~~

POLICY STATEMENT

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Enteral nutrition products may be covered upon authorization when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food *(California Code of Regulations* [CCR], Title 22, Section 51313.3).

The Department of Health Care Services' (DHCS) Medi-Cal pharmacy benefit limits the enteral nutrition product benefit to those products administered through a gastric, nasogastric, or jejunostomy feeding tube, for adults 2~~1~~2 years of age or older, with the exception of products consumer orally for inborn error of metabolism, and products consumed orally for intestinal malabsorption diagnoses. Beneficiaries ~~under~~ 21 years of age and younger are exempt from the enteral nutrition product benefit tube feeding limitation.

Enteral nutrition products are reimbursable through Medi-Cal Rx as a pharmacy-billed item for products administered orally or through a tube. Parenteral services will continue under the medical benefit and be managed by the Alliance or Delegates. Services provided under MediCal Rx are described in the *Enteral Nutrition Products* sections of the Medi-Cal Allied Health Provider Manual.

Unless otherwise indicated, the majority of activities will be applicable to Medi-Cal only.

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The Alliance will seek opportunities to work collaboratively with local county and community agencies through the Memorandum of Understanding (MOU) process to evaluate and meet the needs of these high-risk health plan members.

PROCEDURE

A. Authorization of Therapeutic Enteral Formulas

1. A prescription by a licensed provider is required for medical authorization of enteral nutrition products.
2. Authorization procedures and review for approval of therapeutic enteral formulas will be supervised by qualified healthcare professionals and denials will be reviewed by a qualified physician.
3. The enteral nutrition product requested on an authorization must be on the *List of Enteral Nutrition Products as defined by the Department of Health Services (DHCS)* and the member must meet the medical criteria for the specific product category and, if applicable, product-specific criteria.

   a. Prior Authorization requests for Enteral Nutrition Formula will be made to DHCS utilizing the DHCS 6505 Medi-Cal Rx Enteral Nutrition Prior Authorization Request Form.

   b. Requests for Enteral Nutrition Supplies including syringes, pumps, tubing, etc. will be made directly to AAH using the AAH Prior Authorization Request Form.

   ~~3.~~c. For Group Care (IHSS) Line of Business the Alliance will provide all enterenal nutrition formula and enteral nutrition supplies.

4. Determining medical necessity of enteral nutrition products for medical conditions requires a thorough history, physician examination, nutrition assessment, laboratory testing, feeding observation, when applicable, and evaluation of a member's behavior and home environment.
5. Decisions and appeals regarding therapeutic enteral formula will be performed in a timely manner by Medi-Cal Rx.
6. Services are based on the sensitivity of medical conditions and rendered as:
   ~~a. Emergency requests: no prior authorization required when there is a bona fide emergency requiring immediate treatment.~~
   ~~b.~~a. Expedited requests: within 72 hours ~~three (3) working days~~ for services if a provider or a plan determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
   b. Non-emergency requests: within five (5) working days when proposed treatment meets objective medical criteria, and is not contraindicated.

   ~~c.~~
7. Verbal or written notification will be provided to any provider requesting a service by prior authorization that is denied, approved, or modified in an amount, duration or scope that is less than that requested by the provider by Medi-Cal Rx.

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8. Members will be notified in writing about denied, deferred, or modified services by Medi-Cal Rx.
~~8.~~
9. Both providers and members will be notified about the appeals procedure by Medi-Cal Rx.

~~B. Referrals to Women, Infants and Children's (WIC) Program~~

~~1. Members will ***not*** be referred to WIC for therapeutic enteral formulas because WIC does not receive funding to supply these products or the accompanying services for ongoing evaluation of medical conditions.~~
~~2. Only women who are pregnant, breastfeeding, or postpartum, or the parent/guardian of a child less than 5 years of age will be referred to a local WIC agency for available food supplements and/or nutrition education program services, with documentation of the referral made in the member's medical record.~~
~~3. Providers referring member to WIC will supply the WIC program with a current, and periodically as needed, hemoglobin or laboratory value that has been documented in the member's medical record.~~
~~4. Providers will refer and document referral to the WIC program as part of the member's initial health assessment (IHA) or initial pregnancy evaluation:~~
~~a. A child member under the age of 5 (refer parent/guardian)~~
~~b. Pregnant, breastfeeding, or postpartum members~~

B. Informing Providers and Members
~~C.~~
1. The Alliance will use the Provider Manual and Provider Newsletters to inform providers about:
   a. Prescription and authorization procedures for provision of therapeutic enteral formulas
   b. Timeliness standards
   c. Requirements for periodic physical assessment and follow-up evaluation
   d. Local referral resources
   e. Formulary list of approved therapeutic formulas, and processes for approval of newly marketed therapeutic enteral formulas.
2. The Alliance will inform members about the processes and procedures for provision of medically necessary therapeutic enteral formulas via:
   a. Member EOC
   b. Member Newsletters

~~b.~~

~~D.~~C. Parenteral Nutrition requests will follow the prior authorization process outlined in UM-057 Authorization Service Requests

~~E.~~D. 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*

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DEFINITIONS

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Therapeutic "medical" food is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation (21 U.S.C. 360ee(b)(3)).
Parenteral Nutrition are defined as solutions, suspensions, emulsions for injection or infusion, powders for injection or infusion, gels for injection and implants. They are sterile preparations intended to be administrated directly into the systemic circulation.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
UM-057 Authorization Service Requests

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

10/28/2009, 7/20/2012, 9/6/2012, 10/2/2012, 4/21/2014, 6/25/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 11/23/2021, 1/24/2024

REFERENCES

Medical Services Workflow- Therapeutic Formula Referrals

MMCD Policy Letter 14-003 Enteral Nutrition Products
Medi-Cal Provider Manual - Allied Health, March 2014, Enteral Nutrition Products:

- An Overview
- Elemental and Semi-Elemental
- Metabolic
- Specialized
- Specialty Infant
- Standard

Title 22 §51313.3
Welfare & Institutions Code § 14132.86, 14105.8, 14105.395
Title 42 CFR § 431.63(c)

DHCS Policy – Enteral Nutrition Products, December 2020
DHCS List of Enteral Nutrition Products
DHCS 6505 Medi-Cal Rx Enteral Nutrition Prior Authorization Request Form

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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 Healthcare Quality Committee annually.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-045
Policy Name	Communication Services - UM
Department Name	Health Care Services
Department Owner	Medical Director
Lines of Business	Medi-Cal and Group Care
Effective Date	10/6/2011
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

All Alameda Alliance for Health (AAH) members and providers can access UM staff when seeking information about the authorization/referral process and/or the UM process (such as criteria used and ability to speak with the reviewer). AAH uses multiple means of communication with members about their rights related to UM, benefits, and care.

PROCEDURE

AAH provides the following communication services for members and providers related to the utilization management (UM) reviews and processes:

1. AAH provides the ability to speak with a UM staff member at least 8 hours a day during normal business hours for inbound calls regarding UM issues. This is provided by utilization review staff that is available by phone during normal business hours of 8 am to 5 pm Pacific Time. AAH also offers walk in services to members and providers at its office.

2. After normal business hours inbound calls are received by voice mail and returned the next business day by UM staff. UM staff converts the phones to voice mail at the end of each day and then receive and return the voicemails on the next business day. AAH also provides 24-hour fax capabilities and email for additional inbound communication after normal business hours regarding UM issues. UM staff receives faxes and emails and processes them in accordance with review turnaround times.

3. Staff are available 24 hours, 7 days a week for providers seeking authorizations for post-ER stabilization care. Calls after hours are triaged by AAH clinical staff. Staff are also available on the weekends and holidays during the daytime for assistance with discharge planning and transfers to step down facilities.

4. UM staff sends outbound communications in the form of outbound calls, letters confirming UM decisions, emails, and faxes. The communications comply with the requirements for approval and denial letters in terms of content and timing. UM staff use templates to ensure consistency and review customized communications with the Supervisor prior to sending.

5. When answering the phone all UM staff will identify themselves by their name, title and that the caller has reached AAH when initiating or returning calls regarding UM issues. AAH confirms compliance with this through routine monitoring of phone calls performed by the UM Supervisor. Staff that do not comply are coached on effective communication techniques including providing identification.

6. AAH provides telephone numbers to members and providers that they can use to access the UM department and staff. Providers access the UM department directly through 1(510) 747-4540 and members call Member Services at 1(510)747-4567 or at 1(877) 371-2222. Member Services then warm transfers the member to the UM department during normal business hours. This toll-free number is supplied in newsletters, on the website and in enrollment materials to facilitate access to UM staff. AAH also has a toll-free number to member services and member services staff can warm transfer members and providers to the UM department.

7. AAH maintains a 24/7 telephone line for behavioral health services. See policy BH-002 Behavioral Health Services.

8. Specific AAH UM staff may be onsite at AAH and can communicate directly with members and providers regarding their questions about the UM process. AAH provides access to UM staff 9 hours a day both directly and through coordination with other areas such as provider services or member services that may refer a caller in who has questions about the UM process. The presence of onsite staff will follow any State of California declared Public Health Emergency (PHE) requirements. If staff are not onsite due to the PHE, they are available by phone or fax to assist providers and members.

9. AAH offers TDD/TTY and California Relay services for deaf, hard of hearing or speech-impaired members. All UM staff members are trained in how to assist members in accessing these services or UM staff may access these services themselves directly to assist a member. The information regarding the services is listed on the AAH website, in newsletters to members and providers and in enrollment and orientation materials.

10. AAH offers alternative formats for members with visual impairments, such as auxiliary aids and services, giving primary consideration to the member's request of a particular auxiliary aid or service. AAH will offer the alternative formats aids and services to the member and/or a family member, friend, or associate of a member if required by the ADA, including if said individual is identified as the member's authorized representative (AR), or is someone with whom it is appropriate for AAH to communicate (e.g., a disabled spouse of a member). AAH will accommodate the communication needs of all qualified members with disabilities, including ARs, and be prepared to facilitate alternative format requests for Braille, audio format, large print (no less than 20 point

Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate. AAH will inform a member who contacts AAH regarding an electronic alternative format, that unless the member requests a password protected format, the member will receive notices and information in an electronic format that is not password protected.

a. The member or AR may contact AAH Member Services, UM or the Case Management department if they wish to use an alternative format. Member Services/UM warm transfers the member to the Case Management department during normal business hours. The Case Management department will assist the member to obtain the alternative format aid or service.

b. AAH will calculate the deadline for a member with visual impairment or other disability requiring provision of written materials in alternative formats, to take action from the date of adequate notice, including all deadlines for appeals and aid paid pending.

11. AAH recognizes the diverse cultural and linguistic needs of our members. AAH hires staff in UM and other areas that are bi-lingual, and a list of those staff and their language abilities is kept in a resource guide for UM staff. If a staff member is not available to assist in translating or speaking with the member in their language, AAH has a contracted interpreter service. UM staff are trained in how to access this service.

12. Information regarding how to access UM staff to discuss UM issues is provided in provider denial notifications, the provider manual, and member denial of service notifications. There is a direct telephone number listed for any denial, delay, or modification of a requested service for the healthcare professional that is responsible for the UM decision.

13. The Member Handbook/Evidence of Coverage is always available to members on the AAH website and will be sent to members upon request. The Handbook describes communication methods available to members regarding all aspects of their AAH membership, such as what services do or do not require prior authorization, how to get all types of care in and out of network, how to access emergency services, second opinions, and sensitive services, the availability of care coordination to assist members to obtain care, and how to access all rights, benefits, and resources available to members.

DEFINITIONS

Accessibility – The extent to which a patient can obtain available services when they are needed. ‘Services’ refers to both telephone access and ease of scheduling an appointment, if applicable.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. UM-001 UM Authorization Process
2. BH-002 Behavioral Health Services

REVISION HISTORY

8/2/2012, 4/21/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 1/20/2024

REFERENCES

- NCQA 2014 Health Plan Standards, UM Standard 3.A.
- Alameda Alliance for Health Contract with DHCS, Exhibit A, Attachment 13 Member Services, 1. A. 1 (a)
- DHCS APL 22-002: Alternative Format Selection for Members with Visual Impairments.

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-045
Policy Name	Communication Services - UM
Department Name	Health Care Services
Department Owner	Medical Director
Lines of Business	Medi-Cal and Group Care
Effective Date	10/6/2011
Subcommittee Name	Quality Improvement Health Equity
Subcommittee Approval Date	TBD~~5/19/2023~~
Compliance Committee Approval Date	~~6/20/2023~~TBD

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POLICY STATEMENT

All Alameda Alliance for Health (AAH) members and providers can access UM staff when seeking information about the authorization/referral process and/or the UM process (such as criteria used and ability to speak with the reviewer). AAH uses multiple means of communication with members about their rights related to UM, benefits, and care.

PROCEDURE

AAH provides the following communication services for members and providers related to the utilization management (UM) reviews and processes:

1. AAH provides the ability to speak with a UM staff member at least 8 hours a day during normal business hours for inbound calls regarding UM issues. This is provided by utilization review staff that is available by phone during normal business hours of 8 am to 5 pm Pacific Time. AAH also offers walk in services to members and providers at its office.

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3. Staff are available 24 hours, 7 days a week for providers seeking authorizations for post-ER stabilization care. Calls after hours are triaged by AAH clinical staff. Staff are 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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4. UM staff sends outbound communications in the form of outbound calls, letters confirming UM decisions, emails, and faxes. The communications comply with the requirements for approval and denial letters in terms of content and timing. UM staff use templates to ensure consistency and review customized communications with the Supervisor prior to sending.

5. When answering the phone all UM staff will identify themselves by their name, title and that the caller has reached AAH when initiating or returning calls regarding UM issues. AAH confirms compliance with this through routine monitoring of phone calls performed by the UM Supervisor. Staff that do not comply are coached on effective communication techniques including providing identification.

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7. AAH maintains a 24/7 telephone line for behavioral health services. See policy BH-002 Behavioral Health Services.

8. Specific AAH UM staff may be onsite at AAH and can communicate directly with members and providers regarding their questions about the UM process. AAH provides access to UM staff 9 hours a day both directly and through coordination with other areas such as provider services or member services that may refer a caller in who has questions about the UM process. The presence of onsite staff will follow any State of California declared Public Health Emergency (PHE) requirements. If staff are not onsite due to the PHE, they are available by phone or fax to assist providers and members.

9. AAH offers TDD/TTY and California Relay services for deaf, hard of hearing or speech-impaired members. All UM staff members are trained in how to assist members in accessing these services or UM staff may access these services themselves directly to assist a member. The information regarding the services is listed on the AAH website, in newsletters to members and providers and in enrollment and orientation materials.

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a. The member or AR may contact AAH Member Services, UM or the Case Management department if they wish to use an alternative format. Member Services/UM warm transfers the member to the Case Management department during normal business hours. The Case Management department will assist the member to obtain the alternative format aid or service.

b. AAH will calculate the deadline for a member with visual impairment or other disability requiring provision of written materials in alternative formats, to take action from the date of adequate notice, including all deadlines for appeals and aid paid pending.

~~9.~~

~~10.~~11. AAH recognizes the diverse cultural and linguistic needs of our members. AAH hires staff in UM and other areas that are bi-lingual, and a list of those staff and their language abilities is kept in a resource guide for UM staff. If a staff member is not available to assist in translating or speaking with the member in their language, AAH has a contracted interpreter service. UM staff are trained in how to access this service.

~~11.~~12. Information regarding how to access UM staff to discuss UM issues is provided in provider denial notifications, the provider manual, and member denial of service notifications. There is a direct telephone number listed for any denial, delay, or modification of a requested service for the healthcare professional that is responsible for the UM decision.

~~12.~~13. The Member Handbook/Evidence of Coverage is always available to members on the AAH website and will be sent to members upon request. The Handbook describes communication methods available to members regarding all aspects of their AAH membership, such as what services do or do not require prior authorization, how to get all types of care in and out of network, how to access emergency services, second opinions, and sensitive services, the availability of care coordination to assist members to obtain care, and how to access all rights, benefits, and resources available to members.

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DEFINITIONS

Accessibility – The extent to which a patient can obtain available services when they are needed. 'Services' refers to both telephone access and ease of scheduling an appointment, if applicable.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. UM-001 UM Authorization Process
2. BH-002 Behavioral Health Services

REVISION HISTORY

8/2/2012, 4/21/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 1/20/2024

REFERENCES

- NCQA 2014 Health Plan Standards, UM Standard 3.A.
- Alameda Alliance for Health Contract with DHCS, Exhibit A, Attachment 13 -Member Services, 1. A. 1 (a)
- DHCS APL 22-002: Alternative Format Selection for Members with Visual Impairments.

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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 Healthcare Quality Committee annually.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-050
Policy Name	Tracking and Monitoring of Services Prior Authorized
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	All
Effective Date	3/24/2016
Approval/Revision Date	TBD

POLICY STATEMENT

A. The Alliance maintains a specialty referral system to track and monitor referrals requiring prior authorization. The system includes authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system includes non-contracting providers.

B. Services and specialist referrals that may require prior authorization include:

- Out of network (OON) specialist referrals
- Some in network specialists

Services which require PA is subject to change annually following approval from the HealthCare Quality Committee (HCQC)

C. The Alliance ensures that all contracting health care practitioners are aware of the referral processes and tracking procedures

D. The member's Primary Care Provider (PCP) or treating provider arranges and coordinates any specialty referrals or services which may require a prior authorization.

E. A monitoring process is in place to ensure those authorized services are completed in a timely manner.

PROCEDURE

A. The Alliance Utilization Management Program has an established tracking system for prior authorizations (PA) authorized, denied, deferred, or modified for members assigned to a Directly Contracted Provider (DCP).

B. The Alliance captures all inpatient and outpatient authorization requests for members assigned to a DCP in the Alliance Clinical Information Management system. Refer to Policy and Procedure UM-057 Authorization Service Requests process. The following information, at a minimum, is tracked:

    1. Services requested
    2. Date of request
    3. Date(s) of service(s) requested
    4. Diagnosis
    5. Requesting provider
    6. Rendering provider
    7. Date(s) of service(s) authorized

C. HealthCare Analytics runs a report monthly using data from the Clinical Information System to track, at a minimum, the following:

    1. Authorization turn-around times
    2. Authorization decision approved, partial approved, denied, and deferred
    3. Prior authorizations never utilized
    4. Authorizations for specialist referrals, including out-of-network

D. A monitoring report is in place to ensure those services authorized are utilized within the authorized time duration. The monitoring report identifies all authorizations without a corresponding claim by the mid-cycle of the authorization duration and 90 days following the end of the authorization period.

E. On a monthly basis, the monitoring report for unused authorizations is reviewed by the assigned UM Specialist.

F. For unused authorizations within 60 calendar days of the initial authorization, a reminder letter will be sent to all the members with an authorized service without a corresponding claim. The letter is to remind the member to obtain the authorized services before authorization expiration.

    1. A monthly report with applicable information is sent securely to our mail vendor to send out all letters. A confirmation report for each member is sent from the vendor to AAH for tracking
    2. A copy of reports and confirmation is maintained by the UM Manager.

G. For unused authorization that remain unused greater than 90 calendar days from the end of the authorization period with no corresponding claim, a reminder letter will be sent to the Member and/or Member's Representative and Requesting Provider informing them the authorization has expired and, if needed, how to obtain a new authorization.

Monitoring and Access

Every quarter, the monitoring report will be reviewed and presented to the UM-Subcommittee to evaluate whether there are access constraints for certain providers and specialties. In addition, if there are certain members that have 100% open and unused authorizations, this may warrant case management to help coordinate the member's care.

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/Acronyms:

1) **Directly Contracted Provider (DCP):** provider directly contracted with the Alliance; the Alliance manages the care for members with a PCP directly contracted with the Alliance.
2) **HealthCare Quality Committee (HCQC**): committee comprising of medical services.
3) **Utilization Management Subcommittee:** monthly committee comprising of management from UM, pharmacy, and appeals department to discuss utilization metrics; reports up to HCQC.
4) **Delegated entity**: entity the Alliance contracts with to perform utilization management functions.
5) **Out of Network (OON):** provider not contracted with the Alliance.

AFFECTED DEPARTMENTS/PARTIES

HealthCare Analytics

RELATED POLICIES AND PROCEDURES

UM-057 Authorization Service Request Process

RELATED WORKFLOW DOCUMENTS OR OTHE ATTACHMENTS

REVISION HISTORY

3/24/2016, 12/15/2016, 04/16/2019, 3/19/2020, 5/21/2020, 5/15/21, 5/20/2021, 6/28/2022

REFERENCES

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-050
Policy Name	Tracking and Monitoring of Services Prior Authorized
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	All
Effective Date	3/24/2016
Approval/Revision Date	~~6/28/2022~~TBD

POLICY STATEMENT

A. The Alliance maintains a specialty referral system to track and monitor referrals requiring prior authorization~~—~~. The system includes authorized, denied, deferred, or modified referrals, and the timeliness of the referrals~~—~~. This specialty referral system includes non-contracting providers.

B. Services and specialist referrals that may require prior authorization include:

- Out of network (OON) specialist referrals
- Some in network specialists

Services which require PA is subject to change annually following approval from the HealthCare Quality Committee (HCQC)

C. The Alliance ensures that all contracting health care practitioners are aware of the referral processes and tracking procedures

D. The member's Primary Care Provider (PCP) or treating provider arranges and coordinates any specialty referrals or services which may require a prior authorization.

E. A monitoring process is in place to ensure those authorized services are completed in a timely manner.

PROCEDURE

A. The Alliance Utilization Management Program has an established tracking system for prior authorizations (PA) authorized, denied, ~~deferred~~deferred, or modified for members assigned to a Directly Contracted Provider (DCP).

B. The Alliance captures all inpatient and outpatient authorization requests for members assigned to a DCP in the Alliance Clinical Information Management system. Refer to Policy and Procedure UM-057 Authorization Service Requests process. The following information, at a minimum, is tracked:

1. Services requested
2. Date of request
3. Date(s) of service(s) requested
4. Diagnosis
5. Requesting provider
6. Rendering provider
7. Date(s) of service(s) authorized

C. HealthCare Analytics runs a report monthly using data from the Clinical Information System to track, at a minimum, the following:

1. Authorization turn-around times
2. Authorization decision approved, partial approved, denied, and deferred
3. Prior authorizations never utilized
4. Authorizations for specialist referrals, including out-of-network

D. A monitoring report is in place to ensure those services authorized are utilized within the authorized time duration. The monitoring report identifies all authorizations without a corresponding claim by the mid-cycle of the authorization duration and 90 days following the end of the authorization period.

E. On a monthly basis, the monitoring report for unused authorizations is reviewed by the assigned UM Specialist.

F. For unused authorizations within 60 calendar days of the initial authorization, a reminder letter will be sent to all the members with an authorized service without a corresponding claim. The letter is to remind the member to obtain the authorized services before authorization expiration.

1. A monthly report with applicable information is sent securely to our mail vendor to send out all letters. A confirmation report for each member is sent from the vendor to AAH for tracking
2. A copy of reports and confirmation is maintained by the UM Manager.

G. For unused authorization that remain unused greater than 90 calendar days from the end of the authorization period with no corresponding claim, a reminder letter will be sent to the Member and/or Member's Representative and Requesting Provider informing them the authorization has expired and, if needed, how to obtain a new authorization.

Monitoring and Access

Every quarter, the monitoring report will be reviewed and presented to the UM-Subcommittee to evaluate whether there are access constraints for certain providers and specialties. In addition, if there are certain members that have 100% open and unused authorizations, this may warrant case management to help coordinate the member's care.

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/Acronyms:

1) **Directly Contracted Provider (DCP):** provider directly contracted with the Alliance; the Alliance manages the care for members with a PCP directly contracted with the Alliance.
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4) **Delegated entity**: entity the Alliance contracts with to perform utilization management functions.
5) **Out of Network (OON):** provider not contracted with the Alliance.

AFFECTED DEPARTMENTS/PARTIES

HealthCare Analytics

RELATED POLICIES AND PROCEDURES

UM-057 -Authorization Service Request Process

RELATED WORKFLOW DOCUMENTS OR OTHE ATTACHMENTS

REVISION HISTORY

3/24/2016, 12/15/2016, 04/16/2019, 3/19/2020, 5/21/2020, 5/15/21, 5/20/2021, 6/28/2022

REFERENCES

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-052
Policy Name	Discharge Planning to Lower Level of Care, (Including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	All
Effective Date	05/25/2017
Approval Date	TBD

POLICY STATEMENT

1. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.
2. The attending physician is responsible for evaluating the post - acute admission needs of the member and determine the type of recovery prior to discharge.
3. Administrative bed days will be reviewed under the inpatient authorization process. Administrative bed days will be reviewed for authorization by Alameda Alliance for Health (AAH) while the member is in an acute care inpatient facility which provides a higher level of care than what is needed currently by the member. These days will be authorized when the appropriate guidelines below are followed while the patient remains in an acute care inpatient facility while patient is waiting for a placement in recovery facilities.

4. Post-Acute care Admission to Lower Level of Care
   a) Lower level of care services will be provided to any member who receives a physician's order for transfer to a recovery facility appropriate for his/her medical needs.
5. Transfer to the appropriate recovery facility will be made in a timely manner.
   a) The following settings are considered appropriate for post-acute care admission into lower level of care:

i. Nursing Facility (Skilled and/ or Long-Term Care Custodial)
ii. Sub-Acute Care Facility
iii. Acute Rehab Facility
iv. Long-Term Acute Care Facility (LTAC)
v. Intermediate Care Facility for the Developmentally Delayed (ICF/DD)
vi. Medical Respite Facility

PROCEDURE

A. Discharge Planning to a Lower Level of Care Facility

1. Discharge planning begins at the time of admission for unscheduled patient stays and prior to admission for elective inpatient stays and continues throughout the patient's stay. The patient's progress is evaluated in order to plan for a timely discharge to the appropriate level of care and provision of Transitional Care Services (TCS)

   a) At the time of admission, the hospital discharge planner, case manager or social worker documents the member's discharge planning and TCS needs and associated barriers to discharge in a note.

   b) Transitional Care Services (TCS) includes:

      i. Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility to facilitate the participation of the Care Manager with the discharge planning and follow up.

      ii. Discharge Risk Assessment

      iii. Discharge Planning document

   c) A full description of the Alliance TCS program is found in *CM-034 Transition of Care policy*

2. The discharge plan will be coordinated with the attending physician, the member and/or family, the identified TCS Care Manager, the hospital interdisciplinary staff and lower-level placement facilities. Evaluation of the discharge plan is included in the concurrent review sessions between the Alliance UM Nurse/Reviewer, the Alliance Medical Director and the facility's discharge planning staff. Discharge placement procedures to lower level of care facilities (in network or out of network) is coordinated with the facility and agreed upon prior to placement.
3. The Alliance UM Nurse/Reviewer will review member's needs using the Medi-Cal guidelines and the MCG guidelines for recovery facility placement
4. The Alliance UM Nurse/Reviewer will verify benefits and provide the authorization decision to the hospital for appropriate placement.

5. When significant barriers to placement exist, the Alliance UM Nurse/Reviewer will assist the facility in locating accepting facilities capable of managing the members' care needs. Discharge barriers could include

a) Bariatric Needs

b) Bedside Dialysis Needs

c) Isolation

d) Social Determinants of Health (Including Homelessness)

e) Long-Term Care (Custodial) Placements

f) Aggressive or Wandering Behaviors

g) History of Member Elopement/ AMA

6. The AAH UM staff will assist in contacting potential accepting facilities

a) The AAH UM staff will initiate the Letter of Agreement (LOA) process for Out of Network (OON) facilities that would accept the member for care. The procedure for discharge to the out of network facility will be coordinated with the OON facility and agreed upon before the discharge to ensure that the Member's needs are met during and after the transition. The option to create an ongoing contract with the OON facility will be offered.

b) Case will be discussed at Extended Length of Stay Rounds to identify placement options.

c) If Length of Stay (LOS) is prolonged, the AAH UM staff will escalate the case to AAH clinical and/or operational leadership to develop strategies to locate appropriate placement.

7. Strategies to locate placement may include working administratively with facilities to develop capacity to manage the member's needs, contacting DHCS to assist in problem resolution, and/or identify contractual opportunities regarding placement.

B. Granting Administrative Days Once Patient No Longer Meets Medical Necessity for Acute Patient Stay

1. AAH will authorize administrative bed days in facilities that have Administrative Day level of care in their contract with AAH, if the hospital follows the following guidelines.

2. Day 1:

a) Hospital staff will send a fax blast to a minimum of ten (10) contracted facilities and send confirmation to the Alliance Nurse/Reviewer. Deadline will be 3:00 pm.

b) If the above requirements are completed and member is not placed in a facility:

c) The administrative day will be authorized.

d) The Hospital should plan to initiate the outreach outlined in Day 2 below.

3. Day 2:

a) Hospital staff will attempt to find appropriate placement for the member by calling at least ten (10) contracted lower level of care facilities.

b) Hospital staff will send the list of facilities contacted to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

c) If the above requirements are completed and member is not placed in a facility:

d) The administrative day will be authorized

e) The Hospital should plan to initiate the outreach outlined in Day 3 below

4. Day 3:

a) Hospital staff will call the Alliance UM Nurse/Reviewer for assistance if no placement has been made.

b) Hospital staff will continue to call at least five (5) facilities, send the list of facilities contacted to the Alliance UM Nurse/Reviewer assigned to the hospital where the member is admitted.

c) Hospital staff will record the list of facilities contacted and send it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

d) The Alliance UM staff will send a fax blast to both contracted facilities and non-contracted facilities.

e) The Alliance UM Nurse/Reviewer will also assist by contacting contracted and non-contracted facilities in order to facilitate placement

f) If the above requirements are completed and member is not placed in a facility:

g) The administrative day will be authorized

h) The Hospital should continue to initiate the outreach outlined in Day 4, and Day 5 and ongoing.

5. Day 4:

a) Hospital staff will call at least five (5) facilities and send the list of facilities contacted it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

b) The Alliance UM Nurse/Reviewer may also assist by contacting contracted and non-contracted facilities in order to facilitate placement

6. Day 5: and ongoing days until discharge

a) Hospital staff will call at least five (5) facilities and send the list of facilities contacted it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

b) The Alliance UM Nurse/Reviewer may also assist by contacting contracted and non-contracted facilities in order to facilitate placement

c)The Alliance Nurse/Reviewer will escalate the case to the Managers

d) For complex placements, the Alliance Medical Director may be consulted for medical related issues.

C. Delegation Oversight

1. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities must make sure that hospitals in which their delegated review patients have been admitted comply with the above referenced process with the attendant documentation s. Refer to UM-060 for delegation oversight process.

DEFINITIONS

Discharge Planning - The activities that facilitate a patient's movement from one health care setting to another, or to home. It is a multidisciplinary process involving physicians, nurses, social workers, and possibly other health professionals; its goal is to enhance continuity of care. It begins on admission.

Administrative Days - Inpatient stay days for a member who no longer require acute hospital care and is awaiting placement in a nursing home or other subacute or post-acute care facility.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program

UM-003 Concurrent Review and Discharge Planning Process

UM-051 Timeliness of UM Decision Making

UM-054 Notice of Action

UM-057 Authorization Request

UM-060 Delegation Management and Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment #1 - Request to Discharge Members to Lower Level of Care Proof of Placement Log

REVISION HISTORY

5/25/2017, 03/01/2018, 07/06/2018, 09/06/2018, 11/21/2019, 3/18/2021, 3/22/2022, 6/28/2022, 02/21/2023, 1/25/2024

REFERENCES

DHCS Contract, Exhibit A, Attachment 8
CDPH AFL 10-21

MONITORING

This policy is reviewed annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually for review and approval.

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POLICY AND PROCEDURE

Policy Number	UM-052
Policy Name	Discharge Planning to Lower Level of Care, (Including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Director ~~Medical Director~~ Utilization Management
Lines of Business	All
Effective Date	05/25/2017
Approval Date	~~02/21/2023~~TBD

~~1.0~~ POLICY STATEMENT

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1.~~1~~ The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.

~~1.~~2. The attending physician is responsible ~~to evaluate~~for evaluating the post - acute admission needs of the member and determine the type of recovery prior to discharge.

~~1.~~3. Administrative bed days will be reviewed under the inpatient authorization process. Administrative bed days will be reviewed for authorization by Alameda Alliance for Health (AAH) while the member is in an acute care inpatient facility which provides a higher level of care than what is needed currently by the member. These days will be authorized when the appropriate guidelines below are followed while the patient remains in an acute care inpatient facility while patient is waiting for a placement in recovery facilities.

~~1.~~4. Post-~~-~~Acute care Admission to Lower Level of Care

~~1.4.~~a)~~1~~ Lower level of care services will be provided to any member who receives a physician's order for transfer to a recovery facility appropriate for his/her medical needs.

~~1.~~5. Transfer to the appropriate recovery facility will be made in a timely manner.

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a) ~~1.5.1~~ T~~t~~he following settings are considered appropriate for post-acute care admission into lower level of care:

i. ~~1.5.1.1~~ ~~Skilled~~ Nursing Facility (Skilled and/ or Long-Term Care Custodial)
ii. ~~1.5.1.2~~ Sub-Acute Care Facility
iii. ~~1.5.1.3~~ Acute Rehab Facility
iv. ~~1.5.1.4~~ Long-~~-~~Term Acute Care Facility (LTAC)
v. Intermediate Care Facility for the Developmentally Delayed (ICF/DD)
vi. Medical Respite Facility

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~~2.0~~ PROCEDURE

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~~2.~~A. ~~1~~ Discharge Planning to a Lower Level of Care Facility

~~2.1.~~1. Discharge planning begins at the time of admission for unscheduled patient stays and ~~-~~prior to admission for elective inpatient stays and continues throughout the patient's stay. The patient's progress is evaluated in order to plan for a timely discharge to the appropriate level of care and provision of Transitional Care Services (TCS)

a) ~~2.1.1.2~~ At the time of admission, the hospital discharge planner, case manager or social worker documents the member's discharge planning and TCS needs and associated barriers to discharge in a note.

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b) ~~2.1.1.2.1~~ Transitional Care Services (TCS) includes:

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- i. Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility to facilitate the participation of the Care Manager with the discharge planning and follow up.
- ii. Discharge Risk Assessment
- ~~i.~~iii. Discharge Planning document

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c) A full description of the Alliance TCS program is found in *CM-034 Transition of Care policy*

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2. ~~2.1.1.3~~The discharge plan will be coordinated with the attending physician, the member and/or family, the identified TCS Care Manager, the hospital interdisciplinary staff and lower-level placement facilities. Evaluation of the discharge plan is included in the concurrent review sessions between the Alliance UM Nurse/Reviewer, the Alliance Medical Director and the facility's discharge planning staff. Discharge placement procedures to lower level of care facilities (in network or out of network) is coordinated with the facility and agreed upon prior to placement.

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3. ~~2.1.1.4~~ The Alliance UM Nurse/Reviewer will review member's needs using the Medi-Cal guidelines and the MCG guidelines for recovery facility placement~~.~~

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4. ~~2.1.1.5~~ The Alliance UM Nurse/Reviewer will verify benefits and provide the authorization decision to the hospital for appropriate placement.

5. ~~2.1.1.6~~ When significant barriers to placement exist, the Alliance UM Nurse/Reviewer will assist the facility in locating accepting facilities capable of managing the members' care needs. Discharge barriers could include

a) Bariatric Needs

b) Bedside Dialysis Needs

c) Isolation

d) Social Determinants of Health (Including Homelessness)

e) Long-Term Care (Custodial) Placements

f) Aggressive or Wandering Behaviors

g) History of Member Elopement/ AMA

6.~~2.1.1.6.1~~ The AAH UM staff will assist in contacting potential accepting facilities

a) ~~2.1.1.6.2~~ The AAH UM staff will initiate the Letter of Agreement (LOA) process for Out of Network (OON) facilities that would accept the member for care. The procedure for discharge to the out of network facility will be coordinated with the OON facility and agreed upon before the discharge to ensure that the Member's needs are met during and after the transition. The option to create an ongoing contract with the OON facility will be offered.

b) ~~2.1.1.6.3~~ Case will be discussed at Extended Length of Stay Rounds to identify placement options.

c)

~~2.1.1.6.4~~ If Length of Stay (LOS) is prolonged, the AAH UM staff will escalate the case to AAH clinical and/or operational leadership to develop strategies to locate appropriate placement.

7. ~~2.1.1.6.41~~ Strategies to locate placement may include working administratively with facilities to develop capacity to manage the member's needs, contacting DHCS to assist in problem resolution, and/or identify contractual opportunities regarding placement.

B. ~~2.2~~ Granting Administrative Days Once Patient No Longer Meets Medical Necessity for Acute Patient Stay

1. ~~2.2.1~~ AAH will authorize administrative bed days in facilities that have Administrative Day level of care in their contract with AAH, if the hospital follows the following guidelines.

2. ~~2.2.1.1~~ Day 1:

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a) ~~2.2.1.1.1~~ Hospital staff will send a fax blast to a minimum of ten (10) contracted facilities and send confirmation to the Alliance Nurse/Reviewer. Deadline will be 3:00 pm.

b) ~~2.1.1.1.2~~ If the above requirements are completed and member is not placed in a facility:

c) ~~2.1.1.1.2.1~~ The administrative day will be authorized.

d) ~~2.1.1.1.2.2~~ The Hospital should plan to initiate the outreach outlined in ~~Section 2.2.1.2,~~ Day 2 below.

3. ~~2.2.1.2~~ Day 2:

a) ~~2.2.1.2.1~~ Hospital staff will attempt to find appropriate placement for the member by calling at least ten (10) contracted lower level of care facilities.

b)

~~2.2.1.2.2~~ Hospital staff will send the list of facilities contacted to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

c)

~~2.2.1.2.3~~ If the above requirements are completed and member is not placed in a facility:

d)

~~2.2.1.2.3.1~~ The administrative day will be authorized

e) ~~2.2.1.2.3.2~~ The Hospital should plan to initiate the outreach outlined in ~~Section 2.2.1.3~~ Day 3 below

4. ~~2.2.1.3~~ Day 3:

~~2.2.1.3.1~~a) Hospital staff will call the Alliance UM Nurse/Reviewer for assistance if no placement has been made.

b) ~~2.2.1.3.2~~ Hospital staff will continue to call at least five (5) facilities, send the list of facilities contacted to the Alliance UM Nurse/Reviewer assigned to the hospital where the member is admitted~~.~~

c) ~~2.2.1.3.3~~Hospital staff will record the list of facilities contacted and send it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

~~2.2.1.3.4~~d) The Alliance UM staff will send a fax blast to both contracted facilities and non-contracted facilities.

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~~2.2.1.3.5~~ c) The Alliance UM Nurse/Reviewer will also assist by contacting contracted and non-contracted facilities in order to facilitate placement

~~2.2.1.3.6~~ f) If the above requirements are completed and member is not placed in a facility:

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g) ~~2.2.1.3.6.1~~The administrative day will be authorized

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h) ~~2.2.1.3.6.2~~ The Hospital should continue to initiate the outreach outlined in ~~Section D,~~ Day 4, and Day 5 and ongoing.

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~~2.2.1.4~~5. Day 4:

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~~2.2.1.4.1~~a) Hospital staff will call at least five (5) facilities and send the list of facilities contacted it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

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~~2.2.1.4.2~~b) The Alliance UM Nurse/Reviewer may also assist by contacting contracted and non-contracted facilities in order to facilitate placement

~~2.2.1.5~~6. Day 5: and ongoing days until discharge

~~2.2.1.5.1~~a) Hospital staff will call at least five (5) facilities and send the list of facilities contacted it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

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~~2.2.1.5.2~~b) The Alliance UM Nurse/Reviewer may also assist by contacting contracted and non-contracted facilities in order to facilitate placement

~~c)2.2.1.5.3~~ The Alliance Nurse/Reviewer will escalate the case to the Managers ~~Alliance management~~

d) ~~2.2.2~~ For complex placements, the Alliance Medical Director may be consulted for medical related issues.

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C. ~~2.3~~ Delegation Oversight

1. ~~2.3.1~~ The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities must make sure that hospitals in which their delegated review patients have been admitted comply with the above referenced process with the attendant documentation s. Refer to UM-060 for delegation oversight process.

DEFINITIONS

Discharge Planning - The activities that facilitate a patient's movement from one health care setting to another, or to home. It is a multidisciplinary process involving physicians, nurses, social workers, and possibly other health professionals; its goal is to enhance continuity of care. It begins on admission.

Administrative Days - Inpatient stay days for a member who no longer require acute hospital care and is awaiting placement in a nursing home or other subacute or post-acute care facility.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program

UM-003 Concurrent Review and Discharge Planning Process

UM-051 Timeliness of UM Decision Making

UM-054 Notice of Action

UM-057 Authorization Request

UM-060 Delegation Management and Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment #1 - Request to Discharge Members to Lower Level of Care Proof of Placement Log

REVISION HISTORY

5/25/2017, 03/01/2018, 07/06/2018, 09/06/2018, 11/21/2019, 3/18/2021, 3/22/2022, 6/28/2022, 02/21/2023, 1/25/2024

REFERENCES

~~1.~~ DHCS Contract, Exhibit A, Attachment 8
CDPH AFL 10-21

MONITORING

This policy is reviewed annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually for review and approval.

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POLICY AND PROCEDURE

Policy Number	UM-056
Policy Name	Standing Referrals
Department Name	Health Services
Department Officer	Chief Medical Officer
Policy Owner	Director of Clinical Services
Line(s) of Business	Medi-Cal and Group Care
Effective Date	3/01/2018
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	TBD

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 consistent with benefit coverage. 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

POLICY

1. The Alliance shall maintain a referral management process and may delegate the referral management process to delegated entities.
   1.1. 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.

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.
   2.1. The Alliance may require the PCP to submit a treatment plan during the course of care or prior to the referral from the enrollee as determined by the Medical Director.
   2.2. If a treatment plan is necessary in the course of care and is approved by The Alliance, in consultation with the PCP, specialist, and enrollee, a standing referral shall be made in accordance with the treatment plan.
   2.3. A treatment plan may be deemed unnecessary if The Alliance approves a current

standing referral to a specialist.

2.4. 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.
   3.1. 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.
   3.2. 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.
   3.3. If a treatment plan is deemed necessary in the course of the care and is approved by The Alliance, in consultation with the PCP, specialist. SCC and the enrollee, a referral will be made accordance with the treatment plan.
   3.4. A treatment plan may be deemed unnecessary if The Alliance approves the applicable referral to a specialist or SCC.

4. 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.

5. Authorization and Referral Processes for Standing Referrals
   5.1. 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.
      5.1.1. Standing Referral authorization requests will be processed as a prospective review (a prior authorization request,) to approve, deny, modify or delay based on medical necessity. (HSC 1367.01)
      5.1.2. 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.
      5.1.3. Determinations (authorized, denied, or modified) for a standing referral shall be 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.
      5.1.4. 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.
      5.1.5. The duration of an approved standing referral authorization shall be determined by the Medical Director, as medically appropriate, but shall not exceed one year. 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.

6. Timeliness Standards:

6.1. Determinations within:
6.1.1. Three (3) business days from receipt of request for standing referral.

6.2. Processed Within four (4) business days of the date of the proposed treatment plan, if any, is submitted to the Medical Director.

6.3. Notification – UM staff will generate the letter of notification of the decision to the Member, PCP and Specialist within:
6.3.1. Two (2) calendar days of the final determination for routine request

PROCEDURE

1.0 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.

2.0 Requests for a standing referral are initiated by the PCP/Specialist/Member after the Specialist and PCP agree on the Treatment Plan.

3.0 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.

4.0 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.

5.0 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:
5.1 Member diagnosis
5.2 Required treatment
5.3 Requested frequency and time period
5.4 Relevant medical records
5.5 Other referrals, evaluation, or procedures, if any
5.5.1 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.

6.0 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.

7.0 Medical Director will review each request to ensure the Treatment Plan is appropriate and supported by the PCP and Specialist.

8.0 Medical Director will forward the case with the final determination to the coordinator of record for appropriate notifications to PCP/Specialist and Member.

9.0 Annual Renewals

9.1 Standing referrals are valid for up to one calendar year from the date of the latest determination.
9.2 UM Staff will process authorizations with the approved number of visits based on the approved Treatment Plan.
9.3 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.

10.0 Preventive Care:

10.1 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).

DEFINITIONS / ACRONYMS

1.0 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.

2.0 Criteria means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcomes.

3.0 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.

4.0 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)

5.0 Medically Necessary (Medi-Cal Program): means 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:

5.1 Consistent with nationally accepted standards of medical practice:

5.1.1 "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.

5.1.2 For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.

5.1.3 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

5.1.3.1 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.

6.0 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.

7.0 Member means any eligible beneficiary who has enrolled in the Alliance and who has been assigned to or selected a Plan

8.0 Non-Contracted Provider is a provider of health care services who is not contractually affiliated with AAH

9.0 Prior Authorization or Prospective Review: A type of Organization Determination that occurs prior to services being rendered.

10.0 Provider means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

10.1 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.

11.0 Specialty Care Center means a center that is accredited or designated by an agency

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 which it is accredited or designated.

12.0 Standing Referral means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

13.0 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

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

REVISION HISTORY

3/01/2018, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023

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

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 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-056
Policy Name	Standing Referrals
Department Name	Health Services
Department Officer	Chief Medical Officer
Policy Owner	Director of Clinical Services
Line(s) of Business	Medi-Cal and Group Care
Effective Date	3/01/2018
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	~~6/20/2023~~TBD

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 consistent with benefit coverage. Requests can be made by a member, Primary Care Physician (PCP) or specialist. ~~The Alliance has processes in place by which an~~ The enrollee may receive a standing referral to a specialist or specialty care center (SCC), in accordance with applicable rules ~~and regulations~~ and regulations in accordance with H&S Code section 1374.16

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POLICY

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   2.1. The Alliance may require the PCP to submit a treatment plan during the course of care or prior to the referral from the enrollee as determined by the Medical Director.
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      5.1.4. 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.
      5.1.5. The duration of an approved standing referral authorization shall be determined by the Medical Director, as medically appropriate, but shall not exceed one year. 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.

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9.1 Standing referrals are valid for up to one calendar year from the date of the latest determination.
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5.1.1 "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.

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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

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REVISION HISTORY

3/01/2018, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023

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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 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 – 060
Policy Name	Delegation of Utilization Management
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Health Care Services
Line(s) of Business	Medi-Cal, Group Care
Effective Date	06/16/2016
Approval / Revision Date	TBD

POLICY STATEMENT

The Alliance is responsible for the oversight of delegated Utilization Management (UM) responsibilities. The Alliance ensures the delegate has a systematic and effective Quality Management (QM)/UM program for providing access to quality healthcare services to the Alliance members, consistent with regulatory and contractual standards. Delegated entities are required to have certain Utilization Management components and functions in adherence to DHCS, DMHC, and the Alliance standards to ensure the member's experience and outcomes are front and center. 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 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 QM/UM responsibilities for the delegated entity and the Alliance. Delegates are required to use Alliance approved UM clinical criteria guidelines when performing delegated UM functions on behalf of the Alliance through the delegate agreement. Criteria guidelines requested to be used by delegates that are different from the Alliance guidelines are reviewed and considered for approval annually at the AAH UM Committee.

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

The Alliance Compliance Delegation Oversight Unit is responsible for the management and coordination of delegated activities. The Compliance Department collaborates with each internal department responsible for the delegated activities to identify staff responsible for

being the subject matter expert and coordinate auditing and oversight functions.

PROCEDURE

A. The Alliance will establish a mutually agreed upon delegation agreement with the delegated entity to include UM responsibilities and reporting activities of the delegate, the oversight and monitoring responsibilities and process of the Alliance. It also 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.

B. 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 on whether the areas are applicable to the delegate's contracted responsibilities, annually through the delegation oversight audit, to potentially include but not limited to:

1. Utilization Management (UM) program
2. UM policies and procedures
   a) Including but not limited to inpatient hospital services, outpatient care, Long Term Care, referral program, prior authorization process, over/underutilization, coordination of care, medical records, and mental health services/substance abuse services, if applicable
3. UM committee meeting minutes
4. Authorization case file review, approvals, and denials
5. Out of Plan/Linked and Carve Out Services, e.g. California Children Services (CCS), Early Intervention/Early Start (EPSDT) , Developmental Disability Services (DDS),
6. Initial Health Assessments
7. For Long Term Care:
   - Bed Holds, Leave of Absences, Required timelines for Physician oversight
8. Delegation activity reporting
9. Follow-up of any issues found within the last year's delegation reporting and previous audit(s).

C. Through the annual delegation oversight audit, the Alliance will review the delegated activities and score or assess 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 act on this situation and issue a written corrective action plan and recommendations for improvement to the delegate. The Alliance will evaluate whether deficiencies were corrected, and follow-up on the actions until all are resolved. The delegation audits will review past findings to ensure policies and procedures changes have been effective and evaluate if there are any repeated findings.

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

E. On an annual basis, clinical criteria/guidelines requested to be used by delegates are brought to the Utilization Management Committee for review and potential approval. Delegates may use the approved clinical guidelines. If not approved, the delegate may not use the clinical guidelines.

F. Delegates are required to report UM performance data to the Alliance on an established frequency, e.g., monthly, quarterly, semi-annually and/or annual basis. For UM activities, delegate reports are reviewed by the Alliance UM department to ensure compliance standards are being met.

G. Delegates are required to submit monthly reports in the format of performance data for outpatient and inpatient services. The Alliance has adopted the Health Industry Collaboration Efforts (HICE) UM Reporting Templates. The templates are released annually by HICE and made available to delegates. Delegates are also permitted to submit performance data in a mutually agreed upon format as needed for data that does not conform to the HICE template.

Oversight reports are submitted to the Alliance Compliance Department and routed to the UM Department for review by the Oversight Staff or UM Management. The reports will include a review of the data to the delegate's performance and the Alliance benchmarks and goals. The Alliance UM staff will provide written feedback to the delegate on the timeliness of the delegate's reporting, performance against the benchmark and identify any opportunities for improvement. Opportunities for improvement identified during the review require a formal corrective action plan and will be monitored for improvement toward the goals.

H. As part of its relationship with the delegate, the Alliance provides the following information to the delegate when requested:

1. Member Experience data, e.g. CAHPS, related to UM. On an annual basis, UM staff will provide the results of the member experience data related UM to identify and address opportunities to improve the UM system. Delegates may be included in work-plans to address identified issues or in various workgroups developed to address opportunities that impact multiple delegates.
2. Clinical performance data, e.g. HEDIS measures, ambulatory utilization, hospital utilization, complex case management. On a quarterly basis, the UM staff will review and provide delegate specific performance measures

I. Any cited deficiencies cited by the Department are communicated to the Delegate through a written Corrective Action Plan (CAP) as defined in *CMP-020 Corrective Action Plan.*

J. Delegation reports are reviewed by the Compliance Committee and forwarded to HCQC committee for review. All delegation oversight activities are reported to the HCQC committee for review and recommendations.

K. 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

Complaints and Resolutions
Compliance
Credentialing
Member Services
Quality Improvement
Utilization Management

RELATED POLICIES AND PROCEDURES

QI-111 Delegation of Management and Oversight
CMP-019 Delegation Oversight
CMP-020 Corrective Action Plan

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

6/16/2016, 3/1/2018, 7/19/2018, 11/21/2019, 3/18/2021, 3/22/2022, 02/21/2023, 1/25/2024

REFERENCES

DHCS Contract, Exhibit A, Attachment 4, Section 6
Title 28, CCR 1300.70(b)(2)(G)
NCQA 2018 Standards and Guidelines for the Association of Health Plans, Quality Management and Improvement, Delegation of UM

MONITORING

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

POLICY AND PROCEDURE

Policy Number	UM – 060
Policy Name	Delegation of Utilization Management
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Health Care Services
Line(s) of Business	Medi-Cal, Group Care
Effective Date	06/16/2016
Approval / Revision Date	~~02/21/2023~~TBD

POLICY STATEMENT

The Alliance is responsible for the oversight of delegated Utilization ~~Utilization~~ Management (UM) responsibilities. The Alliance ensures the delegate has a systematic and effective Quality Management (QM)/UM program for providing access to quality healthcare services to the Alliance members, consistent with regulatory and contractual standards. Delegated entities are required to have certain Utilization Management ~~Utilization Management~~ components and functions in adherence to DHCS, DMHC, and the Alliance standards to ensure the member's experience and outcomes are front and center. 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 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 QM/UM responsibilities for the delegated entity and the Alliance. Delegates are required to use Alliance approved UM clinical criteria guidelines when performing delegated UM functions on behalf of the Alliance through the delegate agreement. Criteria guidelines requested to be used by delegates that are different from the Alliance guidelines are reviewed and considered for approval annually at the AAH UM Committee.

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

The Alliance Compliance Delegation Oversight Unit is responsible for the management and coordination of delegated activities. The Compliance Department collaborates with each

internal department responsible for the delegated activities to identify staff responsible for being the subject matter expert and coordinate auditing and oversight functions.

PROCEDURE

A. The Alliance will establish a mutually agreed upon delegation agreement with the delegated entity to include UM responsibilities and reporting activities of the delegate, the oversight and monitoring responsibilities and process of the Alliance. It also 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.

B. 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 on whether the areas are applicable to the delegate's contracted responsibilities, annually through the delegation oversight audit, to potentially include but not limited to:

1. Utilization Management (UM) program
2. UM policies and procedures
   a) Including but not limited to inpatient hospital services, outpatient care, Long Term Care, referral program, prior authorization process, over/underutilization, coordination of care, medical records, and mental health services/substance abuse services, if applicable
3. UM committee meeting minutes
4. Authorization case file review, approvals, and denials
5. Out of Plan/Linked and Carve Out Services, e.g. California Children Services (CCS), Early Intervention/Early Start (EPSDT) , Developmental Disability Services (DDS),
6. Initial Health Assessments
7. For Long Term Care:
   - Bed Holds, Leave of Absences, Required timelines for Physician oversight
8. Delegation activity reporting
9. Follow-up of any issues found within the last year's delegation reporting and ~~last year's~~previous audit(s).

C. Through the annual delegation oversight audit, the Alliance will review the delegated activities and score or assess 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 act on this situation and issue a written corrective action plan and recommendations for improvement to the delegate. The Alliance will evaluate whether deficiencies were corrected, and follow-up on the actions until all are resolved. The delegation audits will review past findings to ensure policies and procedures changes have been effective and evaluate if there are any repeated findings.

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

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~~D.~~E. On an annual basis, clinical criteria/guidelines requested to be used by delegates are brought to the Utilization Management Committee for review and potential approval. Delegates may use the approved clinical guidelines. If not approved, the delegate may not use the clinical guidelines.

~~E.~~F. Delegates are required to report UM performance data to the Alliance on an established frequency, e.g., monthly, quarterly, semi-annually and/or annual basis. For UM activities, delegate reports are reviewed by the Alliance UM department to ensure compliance standards are being met.

~~F.~~G. Delegates are required to submit monthly reports in the format of performance data for outpatient and inpatient services. The Alliance has adopted the Health Industry Collaboration Efforts (HICE) UM Reporting Templates. The templates are released annually by HICE and made available to delegates. Delegates are also permitted to submit performance data in a mutually agreed upon format as needed for data that does not conform to the HICE template.

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~~G.~~H. As part of its relationship with the delegate, the Alliance provides the following information to the delegate when requested:

1. Member Experience data, e.g. CAHPS, related to UM. On an annual basis, UM staff will provide the results of the member experience data related UM to identify and address opportunities to improve the UM system. Delegates may be included in work-plans to address identified issues or in various workgroups developed to address opportunities that impact multiple delegates.
2. Clinical performance data, e.g. HEDIS measures, ambulatory utilization, hospital utilization, complex case management. On a quarterly basis, the UM staff will review and provide delegate specific performance measures

~~H.~~I. Any cited deficiencies cited by the Department are communicated to the Delegate through a written Corrective Action Plan (CAP) as defined in *CMP-020 Corrective Action Plan.*

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~~I.~~J. Delegation reports are reviewed by the Compliance Committee and forwarded to HCQC committee for review. All delegation oversight activities are reported to the HCQC committee for review and recommendations.

~~J.~~K. 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

Complaints and Resolutions
Compliance
Credentialing
Member Services
Quality Improvement
Utilization Management

RELATED POLICIES AND PROCEDURES

QI-111 Delegation of Management and Oversight
CMP-019 Delegation Oversight
CMP-020 Corrective Action Plan

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

6/16/2016, 3/1/2018, 7/19/2018, 11/21/2019, 3/18/2021, 3/22/2022, 02/21/2023, 1/25/2024

REFERENCES

DHCS Contract, Exhibit A, Attachment 4, Section 6
Title 28, CCR 1300.70(b)(2)(G)
NCQA 2018 Standards and Guidelines for the Association of Health Plans, Quality Management and Improvement, Delegation of UM

MONITORING

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

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	~~UM-062~~BH-007
Policy Name	Behavior Health Treatment
Department Name	Health Care Services
Policy Owner	Senior Director, ~~Clinical Services~~Behavioral Health
Line(s) of Business	Medi-Cal; Group Care
Effective Date	3/19/2020
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	~~6/20/2023~~TBD

POLICY

Alameda Alliance for Health (Alliance) provides medically necessary Behavioral Health Treatment (BHT) services for members under the Medi-Cal for Kids and Teens, (formerly Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)) benefit and in accordance with mental health parity requirements. This includes Medi-Cal members under the age of 21 regardless of whether California's Medi-Cal State Plan covers such services for adults.

BHT services include applied behavioral analysis and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the function of a member, including those with or without autism spectrum disorder (ASD). Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

PROCEDURE

The Alliance provides and covers, or arranges, as appropriate, all medically necessary Medi-Cal for Kids and Teens services, including BHT services for its Medi-Cal members through the AAH Behavioral Health department. For the Medi-Cal for Kids and Teens population, state and federal law define a service as "medically necessary" if the service is necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions. A BHT service does not need to cure a condition in order to be covered. Services that maintain or

improve the child's current health condition are considered a clinical benefit and must be covered to

"correct or ameliorate" a member's condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. The Alliance covers all services that prevent a child's condition from worsening or that prevent the development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Therefore, the Alliance covers BHT services regardless of whether the State Medi-Cal benefits covers such services for adults, when the BHT services have an ameliorative, maintenance purpose.

Medical necessity decisions are individualized. The Alliance does not impose service limitations on any MediCal for Kids and Teens benefit other than medical necessity. The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child.

The Alliance has the following criteria applicable for BHT services for members under the age of 21:

1. Alliance members must have a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary;
2. Be medically stable; and
3. Not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.

The Alliance is responsible for coordinating the provision of services with other behavioral health providers, including but not limited to Regional Centers and County Mental Health plans, to ensure that the Alliance and other behavioral health providers are not providing duplicative services.

The Alliance covers the following BHT services for ASD, or where there is suspicion of ASD that is not yet diagnosed:

1. Medically necessary, as defined for the Medi-Cal for Kids and Teens population;
2. Provided and supervised in accordance with the Alliance's behavioral treatment plan that is developed by a BHT service provider who meets the requirements in California's Medi-Cal State Plan; and,
3. Provided by a qualified autism spectrum disorder provider who meets the requirements contained in the Medi-Cal State plan or licensed provider acting within the scope of their licensure.

BHT services for Alliance members without an ASD diagnosis must be:

1. Medically necessary, as defined for the Medi-Cal for Kids and Teens population;
2. Provided in accordance with Alliance's approved behavioral treatment plan; and,
3. Provided by a licensed provider acting within the scope of their licensure.

Medi-Cal does not cover the following as BHT services under the Medi-Cal for Kids and Teens benefit:

1. Services rendered when continued clinical benefit is not expected, unless the

services are determined to be medically necessary.
2. Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
3. Treatment where the sole purpose is vocationally or recreationally-based.
4. Custodial care. For purposes of BHT services, custodial care:
    a. Is provided primarily to maintain the member's or anyone else's safety; and,
    b. Could be provided by persons without professional skills or training.
5. Services, supplies, or procedures performed in a non-conventional setting including, but not limited to, resorts, spas, and camps.
6. Services rendered by a parent, legal guardian, or legally responsible person.
7. Services that are not evidence-based behavioral intervention practices.

BHT services must be provided, observed, and directed under the Alliance's behavioral treatment plan. The behavioral treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline for the specific member being treated. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by the provider of BHT services. The behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer medically necessary under the Medi-Cal for Kids and Teens medical necessity standard. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary.

The approved behavioral treatment plan must also meet the following criteria:

1. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
2. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
3. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
4. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
5. Include the member's current level of need (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
6. Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
7. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the Alliance member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services.
8. Include care coordination that involves the parents or caregiver(s), school, state

disability programs, and other programs and institutions, as applicable.

9. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
10. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community.
11. Include an exit plan/criteria. However, only a determination that services are no longer medically necessary under the Medi-Cal standard can be used to reduce or eliminate services.

Mental Health Parity

Medical necessity decisions are individualized. The Alliance will not impose service limitations on any Medi-Cal for Kids and Teens benefit other than medical necessity. The determination of whether a service is medically necessary for an individual child must be made on a case-by- case basis, taking into account the particular needs of the child. The Alliance will comply with mental health parity requirements when providing BHT services. Treatment limitations for BHT services are not more restrictive than the predominant treatment limitations applied to medical or surgical benefits, including Non-Quantitative Treatment Limitations (NQTLs). Additionally, mental health parity requirements stipulate that the Alliance must disclose utilization management criteria.

Continuity of Care

The Alliance offers members continued access to out-of-network providers of BHT services (continuity of care) for up to 12 months, in accordance with the Department of Health Care Services (DHCS) requirements.

Timely Access Standards

The Alliance must provide BHT services in accordance with timely access standards, pursuant to Welfare and Institutions Code section 14197 and the Alliance contract.

Group Care Requirements for Behavioral Health

A. The Alliance will comply with SB 855, which enacts CA Health and Safety Code §1374.72 and §1374.721 Mental Health and Substance Use Disorder Coverage.
B. In accordance with CA Health and Safety Code §1374.72, the Alliance will cover medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing he 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:
    a. In accordance with the generally accepted standards of mental health and substance use disorder care.
    b. Clinically appropriate in terms of type, frequency, extent, site, and duration.

c. 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.

C. The Alliance will not limit benefits or coverage for MH/SUD to short-term or acute treatment.
D. The Alliance will arrange coverage for out-of- network services for medically necessary treatment of a 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. The Alliance will continue to meet its obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.
E. The Alliance will not limit benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program.
F. In accordance with CA Health and Safety Code §1374.721:
    a. The Alliance will base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care.
    b. The Alliance will apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.
    c. The Alliance will sponsor a formal education program by nonprofit clinical specialty associations to educate all plan staff and delegates contracted to review claims, conduct utilization review, or make medical necessity determinations.
    d. The Alliance and its delegates will Inter-Rater Reliability testing at least annually, to assess the consistency of decision making for those health care professionals involved in applying UM Criteria requiring at a 90% pass rate. The Alliance will immediately provide remediation if the passing threshold is not met. New staff require testing prior to conducting utilization review without supervision.
G. AAH complies with the requirement that contract provisions that reserve discretionary authority to the plan, or agent of the plan, to determine eligibility for benefits or coverage, interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with CA Health and Safety Code §1367.045 of this are void and unenforceable.

DEFINITIONS / ACRONYMS

AFFECTED DEPARTMENTS/PARTIES

Quality Improvement

RELATED POLICIES AND PROCEDURES

UM-012 Care Coordination-Behavioral Health
UM-002 Behavioral Health Services
UM-057 Authorization Requests
UM-001 Utilization Management Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

3/19/2020, 3/18/2021, 3/22/2022, 6/28/2022, 6/20/2023

REFERENCES

1. 1 The CMS Informational Bulletin dated July 7, 2014
2. Title 42 of the United States Code (USC), Section 1396d(r)
3. Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c)
4. 42 USC 1396d(r); Welfare and Institutions Code section 14059.5(b)(1)
5. DHCS APL 23-005: Requirements for Coverage of Medi-Cal for Kids and Teens, Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21
6. DHCS APL 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
7. DHCS APL 19-014: Responsibly for Behavioral Health Treatment Coverage for Members under the age of 21
8. DHCS APL 19-014 RESPONSIBILITIES FOR BEHAVIORAL HEALTH TREATMENT COVERAGE FOR MEMBERS UNDER THE AGE OF 21
9. MMCD All Plan Letter 21-002 Implementation of Senate Bill 855, Mental Health and Substance Use Disorder Coverage
10. DHCS APL 20-018: Ensuring Access to Transgender Services

MONITORING

This policy and procedure will be reviewed annually to ensure it complies with all regulatory and contractual requirements. The Alliance ensures its delegates comply with all applicable state and federal laws and regulations and communicates those requirements when necessary to ensure compliance.

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Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	BH-007
Policy Name	Behavior Health Treatment
Department Name	Health Care Services
Policy Owner	Senior Director, Behavioral Health
Line(s) of Business	Medi-Cal; Group Care
Effective Date	3/19/2020
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	TBD

POLICY

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PROCEDURE

The Alliance provides and covers, or arranges, as appropriate, all medically necessary Medi-Cal for Kids and Teens services, including BHT services for its Medi-Cal members through the AAH Behavioral Health department. For the Medi-Cal for Kids and Teens population, state and federal law define a service as "medically necessary" if the service is necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions. A BHT service does not need to cure a condition in order to be covered. Services that maintain or

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2. Be medically stable; and
3. Not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.

The Alliance is responsible for coordinating the provision of services with other behavioral health providers, including but not limited to Regional Centers and County Mental Health plans, to ensure that the Alliance and other behavioral health providers are not providing duplicative services.

The Alliance covers the following BHT services for ASD, or where there is suspicion of ASD that is not yet diagnosed:

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2. Provided and supervised in accordance with the Alliance's behavioral treatment plan that is developed by a BHT service provider who meets the requirements in California's Medi-Cal State Plan; and,
3. Provided by a qualified autism spectrum disorder provider who meets the requirements contained in the Medi-Cal State plan or licensed provider acting within the scope of their licensure.

BHT services for Alliance members without an ASD diagnosis must be:

1. Medically necessary, as defined for the Medi-Cal for Kids and Teens population;
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3. Provided by a licensed provider acting within the scope of their licensure.

Medi-Cal does not cover the following as BHT services under the Medi-Cal for Kids and Teens benefit:

1. Services rendered when continued clinical benefit is not expected, unless the

services are determined to be medically necessary.
2. Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
3. Treatment where the sole purpose is vocationally or recreationally-based.
4. Custodial care. For purposes of BHT services, custodial care:
    a. Is provided primarily to maintain the member's or anyone else's safety; and,
    b. Could be provided by persons without professional skills or training.
5. Services, supplies, or procedures performed in a non-conventional setting including, but not limited to, resorts, spas, and camps.
6. Services rendered by a parent, legal guardian, or legally responsible person.
7. Services that are not evidence-based behavioral intervention practices.

BHT services must be provided, observed, and directed under the Alliance's behavioral treatment plan. The behavioral treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline for the specific member being treated. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by the provider of BHT services. The behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer medically necessary under the Medi-Cal for Kids and Teens medical necessity standard. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary.

The approved behavioral treatment plan must also meet the following criteria:

1. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
2. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
3. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
4. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
5. Include the member's current level of need (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
6. Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
7. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the Alliance member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services.
8. Include care coordination that involves the parents or caregiver(s), school, state

disability programs, and other programs and institutions, as applicable.

9. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
10. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community.
11. Include an exit plan/criteria. However, only a determination that services are no longer medically necessary under the Medi-Cal standard can be used to reduce or eliminate services.

Mental Health Parity

Medical necessity decisions are individualized. The Alliance will not impose service limitations on any Medi-Cal for Kids and Teens benefit other than medical necessity. The determination of whether a service is medically necessary for an individual child must be made on a case-by- case basis, taking into account the particular needs of the child. The Alliance will comply with mental health parity requirements when providing BHT services. Treatment limitations for BHT services are not more restrictive than the predominant treatment limitations applied to medical or surgical benefits, including Non-Quantitative Treatment Limitations (NQTLs). Additionally, mental health parity requirements stipulate that the Alliance must disclose utilization management criteria.

Continuity of Care

The Alliance offers members continued access to out-of-network providers of BHT services (continuity of care) for up to 12 months, in accordance with the Department of Health Care Services (DHCS) requirements.

Timely Access Standards

The Alliance must provide BHT services in accordance with timely access standards, pursuant to Welfare and Institutions Code section 14197 and the Alliance contract.

Group Care Requirements for Behavioral Health

A. The Alliance will comply with SB 855, which enacts CA Health and Safety Code §1374.72 and §1374.721 Mental Health and Substance Use Disorder Coverage.
B. In accordance with CA Health and Safety Code §1374.72, the Alliance will cover medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing he 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:
    a. In accordance with the generally accepted standards of mental health and substance use disorder care.
    b. Clinically appropriate in terms of type, frequency, extent, site, and duration.

c. 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.

C. The Alliance will not limit benefits or coverage for MH/SUD to short-term or acute treatment.
D. The Alliance will arrange coverage for out-of- network services for medically necessary treatment of a 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. The Alliance will continue to meet its obligation to ensure its contracted network provides readily available and accessible health care services to each of the plan's enrollees throughout its service area.
E. The Alliance will not limit benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program.
F. In accordance with CA Health and Safety Code §1374.721:
    a. The Alliance will base medical necessity determinations or utilization review criteria on current generally accepted standards of mental health and substance use disorder care.
    b. The Alliance will apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.
    c. The Alliance will sponsor a formal education program by nonprofit clinical specialty associations to educate all plan staff and delegates contracted to review claims, conduct utilization review, or make medical necessity determinations.
    d. The Alliance and its delegates will Inter-Rater Reliability testing at least annually, to assess the consistency of decision making for those health care professionals involved in applying UM Criteria requiring at a 90% pass rate. The Alliance will immediately provide remediation if the passing threshold is not met. New staff require testing prior to conducting utilization review without supervision.
G. AAH complies with the requirement that contract provisions that reserve discretionary authority to the plan, or agent of the plan, to determine eligibility for benefits or coverage, interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with CA Health and Safety Code §1367.045 of this are void and unenforceable.

DEFINITIONS / ACRONYMS

AFFECTED DEPARTMENTS/PARTIES

Quality Improvement

RELATED POLICIES AND PROCEDURES

UM-012 Care Coordination-Behavioral Health
UM-002 Behavioral Health Services
UM-057 Authorization Requests
UM-001 Utilization Management Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

3/19/2020, 3/18/2021, 3/22/2022, 6/28/2022, 6/20/2023

REFERENCES

1. 1 The CMS Informational Bulletin dated July 7, 2014
2. Title 42 of the United States Code (USC), Section 1396d(r)
3. Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c)
4. 42 USC 1396d(r); Welfare and Institutions Code section 14059.5(b)(1)
5. DHCS APL 23-005: Requirements for Coverage of Medi-Cal for Kids and Teens, Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21
6. DHCS APL 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
7. DHCS APL 19-014: Responsibly for Behavioral Health Treatment Coverage for Members under the age of 21
8. DHCS APL 19-014 RESPONSIBILITIES FOR BEHAVIORAL HEALTH TREATMENT COVERAGE FOR MEMBERS UNDER THE AGE OF 21
9. MMCD All Plan Letter 21-002 Implementation of Senate Bill 855, Mental Health and Substance Use Disorder Coverage
10. DHCS APL 20-018: Ensuring Access to Transgender Services

MONITORING

This policy and procedure will be reviewed annually to ensure it complies with all regulatory and contractual requirements. The Alliance ensures its delegates comply with all applicable state and federal laws and regulations and communicates those requirements when necessary to ensure compliance.

POLICY AND PROCEDURE

Policy Number	UM-063
Policy Name	Gender Affirmation Surgery and Services
Department Name	Health Care Services-Utilization Management
Policy Owner	Medical Director of Utilization Management
Line(s) of Business	Medi-Cal and Group Care
Effective Date	11/21/2013
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	1/26/2024
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (the "Alliance") covers gender affirming medically necessary care for transgender and gender diverse members, consistent with the World Professional Association of Transgender Health (WPATH) Standard of Care for Transgender and Gender Nonconforming People for Group Care and Medi-Cal. Gender affirming medically necessary care for Medi-Cal members is consistent with the State Medi-Cal benefit **APL 20-018**.

1. The Alliance provides medically necessary covered services to all Medi-Cal beneficiaries and Group Care enrollees, including transgender diverse (TGD) beneficiaries Gender diverse people includes but is not exhaustive to include non-binary, eunuch, and intersex individuals.
2. Medically necessary covered services are those services:
   a. Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. **(Title 22 California Code of Regulations §51303).**
   b. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. **(Welfare and Institutions Code section 14059.5.)**
   c. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. **(Title 42 USC 1396d(r)(5)).**

d. "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 current 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 provide **(Health and Safety Code section 1374.72 (3) (A)).**

3. The Alliance considers the following treatment medically necessary for all Members with gender dysphoria/gender incongruence:
   a. Mental health services, including psychotherapy;
   b. Gender affirmation (GA) feminizing/masculinizing hormone therapy and/or puberty blocker hormone therapy with clinical monitoring for efficacy and adverse events;
   c. GA surgery that is not strictly cosmetic in nature but addresses gender dysphoria/incongruence and/ or reconstructive services.
4. The Alliance must provide medically necessary reconstructive surgery to all Medi-Cal beneficiaries, including TGD beneficiaries. Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) to improve function. (B) to create a normal appearance, to the extent possible" **(Health and Safety Code § 1367.63m (c) (1) (A) (B)).**
5. In analyzing GA medical and surgical service requests, the Alliance must analyze GA requests under both the applicable medical necessity standard for services to treat gender dysphoria/incongruence and under the statutory criteria for reconstructive surgery. A finding of either "medically necessary to treat gender dysphoria" or "meets the statutory criteria of reconstructive surgery" serves as a separate basis for approving the request.
6. If the Alliance determines that the service is medically necessary to treat the member's gender dysphoria/incongruence, the Alliance must approve the requested service. If the Alliance determines the service is not medically necessary to treat gender dysphoria/incongruence (or if there is insufficient information to establish medical necessity), the Alliance must still consider whether the requested service meets the criteria for reconstructive surgery, taking into consideration the gender with which the member identifies.
7. The request for transgender services should be supported by evidence of either medical necessity or evidence supporting the criteria for reconstructive surgery. Supporting documentation should be submitted, as appropriate, by the member's primary care provider ("PCP"), licensed mental health professional, and/or surgeon. These providers should be qualified and have experience in transgender health care.
8. The Alliance will cover medically necessary medications to treat gender dysphoria/incongruence,, mental health or substance use disorders.

9. The Alliance is required to treat beneficiaries consistent with their gender identity **(Title 42 United States Code §18116; 45 Code of Federal Regulations (CFR) §§92.206, 92.207; see also 45 CFR § 156.125).**
10. Federal regulations prohibit the Alliance from denying or limiting coverage of any health care services that are ordinarily or exclusively available to beneficiaries of one gender, to a TGD beneficiary based on the fact that a beneficiary's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available **(45 CFR §§92.206, 92.207 (b) (3)).**
11. DHCS indicates that Federal regulations further prohibits the Alliance from categorically excluding or limiting coverage for health care services related to gender **transition (45 CFR §92.207 (b) (4)).**
12. The Insurance Gender Nondiscrimination Act ("IGNA") prohibits the Alliance from discriminating against individuals based on gender, including gender identity or gender expression **(Health and Safety Code section § 1365.5).** The IGNA requires that the Alliance provide transgender beneficiaries with the same level of health care benefits available to non-transgender beneficiaries.
13. The Alliance may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive surgery determination, and/or apply appropriate utilization management criteria that are non-discriminatory. The Alliance may not categorically exclude health care services related to gender transition on the basis that it excludes those services for all members.
14. The Alliance must not categorically limit a service or the frequency of services available to a TGD member. For example, classifying certain services, such as facial feminization surgery as always "cosmetic" or "not medically necessary for any Medi-Cal member" is an impermissible "categorical exclusion" of the service. The Alliance must consider each requested service on a case-by-case basis and determine whether the requested service is either "medically necessary to treat the member's gender dysphoria" or meets the statutory definition of "reconstructive surgery."
15. In the case of TGD beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies (target gender).
16. 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 gender dysphoria/incongruence then it would be medically necessary.

PROCEDURE

Gender dysphoria (defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5) is treated with the following core services:

- Behavioral health services;
- Psychotherapy;

- GA feminizing/ masculinizing hormone and/or puberty blocker hormone therapy with clinical monitoring for efficacy and adverse events;
- Surgical and GA procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender, which is not strictly cosmetic in nature. Sex reassignment surgery (also known as GA surgery), is a treatment option for TGD beneficiaries.

People with gender dysphoria/ incongruence often report a feeling of being born into the wrong sex. Sex reassignment is not a single surgical procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual to achieve successful behavioral and medical outcomes.

Before undertaking sex reassignment surgery, important medical and mental health assessments should be undertaken to confirm that surgery is the most appropriate treatment choice for the individual.

Clinical guidance for the medical treatment of gender dysphoria is provided by the World Professional Association for Transgender Health (WPATH) 2022, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People [8th Version]. https://doi.org/10.1080/26895269.2022.2100644. The WPATH Standards of Care falls under the UM 001 Hierarchy for Regulatory and Contractual Requirements for national specialty guidelines. Clinical guidance for the treatment of Substance Abuse Disorder is provided by American Society of Addiction Medicine, ASAM Criteria, 4th edition (2023). Clinical guidance for mental health disorders (age 18 or older) is provided by the American Association of Community Psychiatrist, Level of Care Utilization Systems (LOCUS), Version 20. Clinical guidance for the treatment of mental health disorders (age 6-17 years) is provided by the American Association of Community Psychiatrist, Child, and Adolescent Level of Care Utilization System (CALOCUS), Version 20; or the American Academy of Child and Adolescent Psychiatry, the Child and Adolescent Level of Care/Service Intensity Instrument (CALOCUS-CASII). Edition 1.2 (2020). Clinical guidance for the treatment of mental health disorders (ages 0-5 years) is provided by the American Academy of Child and Adolescent Psychiatry, Early Childhood Service Intensity Instrument (ESCII).

The medical appropriateness of surgical services requested by a TGD beneficiary must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the beneficiary's primary care provider or specialist; often it is a multidisciplinary team involved their care**.** The medical necessity and determination of a surgical procedure GA related or as reconstructive will be made by the Managed Care Plan.

I. Assess, Diagnose, and Discuss Treatment Options for Mental Health or Medical Conditions

Clients presenting with gender dysphoria/incongruence may have underlying mental health or medical conditions. This could include unique anatomical, social, psychosocial, and medical comorbidity considerations. Multidisciplinary teams

including a mental health professional, GA specialist and/ or surgeon, other specialists, and PCP are often involved. Adolescents uniquely will need a biopsychosocial assessment before proceeding with GA medical or surgical interventions.

Although not an explicit criterion, a staged process that is defined by a surgeon in coordination with the member, is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions. New assessments and letters for each GA procedure are not required; multi-staged procedures do not require new mental health reapprovals. The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

The intent of this suggested sequence is to give adolescents and adults sufficient opportunity to experience and socially adjust to the new gender role and achieve the desire optimal hormonal result. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression. It is recommended that health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment and hormonal treatment until the transition is made to adult care.

II. Written Assessment to Support Gender Affirming Hormone Therapy or Surgical Procedures. (1 Letter/ Documentation)

One written documentation or letter is required from a qualified health professional who has competency in the assessment of TGD people, to recommend for medical or surgical treatment. This can be a single letter that summarizes the single opinion for medically necessary GA treatment.

Adolescents will additionally need a comprehensive biopsychosocial assessment: including input from relevant mental health and medical professionals. Involvement of parents(s)/ guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible[1]. A single letter from the adolescent's multidisciplinary team is needed and this letter can summarize the assessment and opinion from the team or single provider involving both medical and mental health professionals (American Psychological Association, 2015; Hembree et al., 2017; Telfer et al., 2018). It is recommended but not required for the health care

[1] This includes people who were declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions. A parent/guardian signature is not required in the case of emancipated minors. (Cal. Fam. Code § 7122); (Cal. Fam. Code § 7002).

professional to liaise with multidisciplinary trans health professionals who are from different disciplines within the field of trans health.

Although not explicit criteria, the recommended content of the letter for GA hormone therapy or surgical intervention from a health care professional who has competency in the assessment of TGD people is as follows:

- The client's general identifying characteristics
- An explanation that the criteria for GA hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy
- Results of the members' psychosocial assessment (if applicable), including review of any medical or mental health diagnoses that may negatively interfere with the proposed GA treatments; risks and benefits were discussed before a treatment decision is made
- The duration of the referring health professional's relationship with the client, including the type of evaluation, therapy, or counseling to date
- A statement that informed consent has been obtained from the member or parent/ guardian.
- A statement that the referring health professional is available for coordination of care before and after interventions are initiated and for the duration of hormonal therapy

An assessment and psychosocial interventions for adolescents are often provided within a multidisciplinary gender identity specialty service. For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the member's chart as a comprehensive assessment. Although not explicit criteria, if such a multidisciplinary service is not available, then the health plan recommends that a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist[2] for the purpose of assessment, education, and involvement in any GA decisions.

If the GA surgeries are staged a single letter that outlines multiple staged interventions is also acceptable. The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

III. Eligibility Criteria for Gender-Affirming Hormone Therapy or Puberty Blocker Hormones for Adolescents (<18 Years Old)

[2] If puberty blockers or gender-affirming hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone prescribing provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

Feminizing/ masculinizing hormone therapy (or puberty blockers) may lead to irreversible physical changes. All of the criteria below must be met:

1. Gender dysphoria/ gender incongruence is marked and sustained.
2. Meets the criteria for diagnostic criteria for gender dysphoria/ gender incongruence;
3. Demonstrates the emotional and cognitive maturity required to provide informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives[3].
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and GA medical treatments have been addressed; sufficient so that GA medical treatments can be provided optimally;
5. The adolescent has been informed of the reproductive effects, including potential loss of fertility and options for fertility preservation, and the context of the adolescent's stage of puberty development;
6. The adolescent has reached Tanner stage 2

IV. Eligibility Criteria Gender Affirming Hormone Therapy for Adults (≥ 18 Years Old)

All of the following criteria must be met:

1. Gender dysphoria/ gender incongruence is marked and sustained;
2. Meets diagnostic criteria for gender dysphoria/ gender incongruence prior to initiating GA hormone treatment;
3. Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;
4. Other possible causes of apparent gender dysphoria/ gender incongruence have been identified and excluded;
5. Mental health and physical conditions that could negatively impact the outcome of the treatment have been assessed, with risks and benefits discussed;
6. Understands the effects of GA hormone treatment on reproduction and they have explored reproductive options.

V. Gender Affirmation Surgery

A. Eligibility Criteria for Gender Affirmation Surgery in Adolescents (< 18 Years Old)

For adolescents undergoing GA surgery, the procedure is medically necessary when all of the following criteria are met (1 through 8):

[3] This includes people who were declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions. A parent/guardian signature is not required in the case of emancipated minors. (Cal. Fam. Code § 7122); (Cal. Fam. Code § 7002).

1. Gender dysphoria/ gender incongruence is marked and sustained;
2. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
3. Demonstrates the emotional and cognitive maturity required to provider informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives;
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and GA medical treatments have been addressed; sufficient so that GA medical treatments can be provided optimally;
5. Informed of the reproductive effects, including potential loss of fertility and the available options to preserve fertility;
6. At least 12 months of GA hormone therapy or longer, if required, to achieve the desired surgical result for GA procedures, including breast growth and skin expansion prior to breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty (with or without scrotoplasty), and facial surgery as part of GA treatment unless hormone therapy is either not desired or is medically contraindicated.

B. Gender Affirming Surgery in Adults (≥ 18 Years Old)

For adults undergoing GA surgery, the procedure is medically necessary when all of the following criteria are met (1 through 7):

1. Gender dysphoria/ gender incongruence is marked and persistent;
2. Meets diagnostic criteria for gender incongruence prior to GA surgery interventions;
3. Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;
4. Understands the effect of GA surgical intervention on reproduction and they have explored reproductive options;
5. Other possible causes of apparent gender dysphoria/ incongruence have been identified and excluded;
6. Mental health and physical conditions that could negatively impact the outcome of GA surgical intervention have been assessed, and risks and benefits have been discussed;
7. Stable on their GA hormonal treatment regimen (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).

If requesting a GA gonadectomy surgery (i.e., Hysterectomy and/or salpingo-oophorectomy, or orchiectomy) although not an explicit criterion, it is recommended that:

- The member has tolerated a minimum of 6 months of hormonal therapy (or longer period if required to achieve the desired surgical result), unless hormones are not clinically indicated, not desired, or medically contraindicated[4].

These criteria do not apply to members who are having these surgical procedures for medical indications other than gender dysphoria/ gender incongruence.

D. FACIAL FEMINIZATION SURGERY & VOICE AND COMMUNICATION THERAPY

Facial feminization surgery (including chondrolaryngoplasty/ vocal cord surgery) is considered a medically necessary to correct a significant physical functional impairment related to treating gender dysphoria/ gender incongruence, and/ or improve the physical functional impairment respectively. Examples include, but are not limited to, reconstructive procedures which correct or improve a significant functional impairment of speech, such as voice feminization/ modification surgery, nutrition, control of secretions, protection of the airway, or corneal protection. The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's request for facial reconstruction surgery. **All basic GA surgery criteria must be met (1-7).**

Facial feminization surgery is considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, trauma, or treatment of a disease or congenital defect, or to treat gender dysphoria/ gender incongruence. Facial feminization surgery is considered not medically necessary when performed strictly to alter or reshape normal structures of the body in order to improve appearance (cosmetic in nature).

Note: The initial restoration may be completed in stages. New mental health assessments and letters are not required for each staged GA procedure; they do not require reapproval.

Voice feminization surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective. All basic GA surgery criteria must be met (1-7).

Although not explicit criterion, it is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication.

[4] The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention.

These criteria do not apply to members who are having these surgical procedures for medical indications other than gender dysphoria/ gender incongruence, or physical functional impairment/ physical reconstruction.

Voice and communication therapy may be medically necessary to treat gender dysphoria/incongruence, or to help individuals develop verbal (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication skills (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity through individual and/or group sessions, and to prevent the possibility of vocal misuse and long-term vocal damage. Therapy is conducted with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/ speech-language pathologists. These pre and post interventions may be needed after voice surgery, or testosterone therapy.

For the following GA reconstructive procedures:

All basic GA surgery criteria must be met (1-7). Additionally, they are medically necessary if they treat gender dysphoria/incongruence, or to treat physical functional impairment/ physical reconstruction. The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's requested facial reconstruction surgery.

1. **Blepharoplasty, Blepharoptosis Repair, and Brow Lift**
   Upper eyelid blepharoplasty or blepharoptosis repair is considered medically necessary for ANY of the following conditions.

2. To treat gender dysphoria/gender incongruence;

a. Difficulty tolerating a prosthesis in an ophthalmic socket; or
b. Repair of a functional defect caused by trauma, tumor, or surgery; or
c. Periorbital sequelae of thyroid disease; or
d. Nerve palsy

Note: For cases where combined procedures (for example, blepharoplasty and brow lift) are requested, the individual must meet the criteria for each procedure.

3. Blepharoplasty

Unilateral or bilateral upper eyelid blepharoplasty is considered medically necessary to relieve obstruction of central vision when the following criteria are met (a or b, and c-d):

a. To treat gender dysphoria/gender incongruence; or
b. Documented complaints of interference with vision or visual field-related activities causing significant functional impact such as difficulty reading or

driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin; and

c. There is either redundant skin overhanging the upper eyelid margin and resting on the eyelashes or significant dermatitis on the upper eyelid caused by redundant tissue; and

d. Prior to manual elevation of redundant upper eyelid skin (taping), the superior visual field is:

1) less than or equal to 20 degrees, or there is a 30 percent loss of upper field of vision compared to normal; and

2. Manual elevation (taping) of the redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

4. Eye Lid Surgery (Blepharoptosis Repair)

Blepharoptosis repair is considered medically necessary to relieve obstruction of central vision when the following criteria are met (a or b, c through e):

a. To treat gender dysphoria/gender incongruence; or
b. Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to eyelid position; and
c. Photographs taken with the camera at eye level and the individual looking straight ahead, document the abnormal lid position (photos should be submitted for review); and
d. Prior to manual elevation of the upper eyelid and redundant upper eyelid skin (taping), the superior visual field is a) less than or equal to 20 degrees or b) there is a 30 percent loss of upper field of vision compared to normal, or c) the margin reflex distance between the pupillary light reflex and the upper eyelid skin edge is less than or equal to 2.0 mm; and
e. Manual elevation (taping) of the upper eyelid and redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

5. Brow Lift

Brow lift (that is, repair of brow ptosis due to laxity of the forehead muscles) is considered medically necessary when the following criteria are met (a or b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. Brow ptosis is causing a functional impairment of upper/outer visual fields with documented complaints of interference with vision or visual field related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin; and

c. Photographs show the eyebrow below the supraorbital rim.

Blepharoplasty, blepharoptosis repair, or brow lift for visual field defects is considered not medically necessary when the criteria noted above are not met.

- Blepharoplasty, blepharoptosis repair, or brow lift is considered not medically necessary when performed strictly to alter or reshape normal structures of the body in order to improve appearance.

- Lower lid blepharoplasty is considered not medically necessary.

- Blepharoplasty, blepharoptosis repair or brow lift procedures which are intended to correct a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect are considered reconstructive in nature, or there is a medical need to treat gender dysphoria/gender incongruence**.**

6. Otoplasty

Otoplasty is considered medically necessary when performed to surgically correct a physical structure or absence of a physical structure that is causing hearing loss, or intended to facilitate the use of a hearing aid or device when both of the following criteria are met (a or b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. The procedure is reasonably expected to improve the physical functional impairment; and

c. An audiogram documents a loss of at least 15 decibels in the affected ear(s).

Otoplasty is considered reconstructive when intended to restore a significantly abnormal external ear or auditory canal related to accidental injury, disease, trauma, or treatment of a disease or congenital defect, or there is a medical need to treat gender dysphoria/gender incongruence**.**

Otoplasty is considered reconstructive when intended to restore the absence of the external ear due to accidental injury, disease, trauma, or the treatment of a disease or congenital defect, or there is a medical need to treat gender dysphoria/gender incongruence**.**

Otoplasty is considered not medically necessary when performed strictly to alter or reshape normal structures of the body to improve appearance. Examples include, but are not limited to, repair of ear lobes with clefts or other consequences of ear piercing, or protruding ears.

Otoplasty is considered not medically necessary when the gender dysphoria/gender incongruence, or medically necessary reconstructive criteria in this section are not met.

7. Nasal Procedures - Rhinoplasty or rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)

Rhinoplasty is considered medically necessary when both of the following criteria are met (a or b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. The medical record documentation includes evidence of the failure of conservative medical therapy for severe airway obstruction from deformities due to disease, structural abnormality, or previous therapeutic process that will not respond to septoplasty alone; and

c. The procedure can be reasonably expected to improve the physical functional impairment;

- Rhinoseptoplasty is considered medically necessary when gender dysphoria/gender incongruence, or the criteria above for rhinoplasty are met and medically necessary criteria in MCG guideline ACG: A-0182 Septoplasty are also met.

- Rhinoplasty is considered reconstructive if there is documented evidence (that is, radiographs or appropriate imaging studies) of nasal fracture resulting in significant variation from normal without physical functional impairment, or to treat gender dysphoria/gender incongruence. The intent of the surgery is to correct the deformity caused by the nasal fracture.

- Rhinoseptoplasty is considered reconstructive if there is documented evidence (that is, radiographs or appropriate imaging studies) of nasal and septal fracture resulting in significant variation from normal without physical functional impairment, or to treat gender dysphoria/gender incongruence. The intent of the surgery is to correct the deformity caused by the nasal and septal fracture.

- Rhinoplasty or rhinoseptoplasty to modify the shape or size of the nose is considered not medically necessary when the gender dysphoria/gender incongruence medical necessity, or reconstructive criteria in this section are not met.

8. Face lift (Rhytidectomy)

Rhytidectomy is considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, and trauma, treatment of a disease or congenital defect, or to treat gender dysphoria/gender incongruence. Examples include, but are not limited to, significant burns or other significant major facial trauma.

Rhytidectomy is considered not medically necessary when the gender dysphoria/gender incongruence, or reconstructive criteria in this section are not met, including but not limited to, removal of wrinkles, excess skin, or to tighten facial muscles.

9. Hair Removal

Hair removal consultation is covered for the genital area when authorization is in place for gender GA surgery, or it is necessary intervention in preparation for surgery. Consultation is needed for the removal of body hair for feminization from the face, chest, back, abdomen, genitalia, arms, and legs if there is persistent gender dysphoria/ gender incongruence, or there is significant disruption of professional and/ or social life because of hirsutism with some medical evaluation outlining the psychological distress related to unwanted hair and justification of medical necessity. Other medical reasons may include if a hair loss response has not been noticed after one year of hormone treatment. Hair reduction procedures include:

(a) Laser Epilation/Hair Removal require:

(i) to be provided by a physician, PA, NP, or RN (requires physician supervision);
(ii) Informed consent;
(iii) Documentation justifying laser hair removal for specific body areas

(b) Electrolysis Hair Removal require:

(i) Documentation of consultation by a physician, PA, NP, or RN (requires physician supervision);
(ii) Informed consent;
(iii) Documentation justifying laser hair removal for specific body areas
(iv) Justification as to why a trial of laser hair removal should not proceed electrolysis;
(v) Electrolysis will be provided by a licensed electrologist.

E. Additional Procedures for Body Feminization or Body Masculinization

The following procedures are medically necessary when they are requested for the treatment of gender dysphoria/ gender incongruence, or reconstructive surgery (to correct or repair abnormal structures of the body to create a normal appearance for the target gender to the extent possible). All basic GA surgery criteria must also be met (1-7). The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's requested surgical or reconstructive procedure.

- Abdominoplasty
- Body contouring (liposuction, lipofilling, Implants, monsplasty/ mons reduction)
- Cheek surgery
- Chin Shaping
- Facial bone reconstruction
- Gluteal augmentation
- Hair removal/ hairplasty, when the criteria above have not been met.
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement

- Suction-assisted Lipoplasty/ trunk contouring
- Otoplasty
- Tattoo (i.e., nipple/ areola)
- Penile prosthesis in the setting of proposed or completed phalloplasty
- Thyroid cartilage reduction/Tracheal shave feminization (larygeochondroplasty)
- Voice Modification Surgery

F. Revisions of Gender-Affirming Surgery (1 Letter Assessment)
The Alliance authorizes requests for surgical revision on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity to treat gender dysphoria/ gender incongruence and/or reconstructive surgery. Clinical documentation must support medical necessity to treat gender dysphoria/ gender incongruence or reconstructive surgery. Surgical revision requests require all of the following:

a. Medical and/or functional complications of prior GA procedure;
b. Measurements and/or photographs of deformity/asymmetry (if applicable);
c. Members who regret their GA surgical intervention are to be managed by an expert multidisciplinary team.
d. Endorsement of medical necessity or reconstructive purpose from the performing surgeon.

The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

VI. Standard Fertility Preservation Services
For coverage options please refer to the UM-057 policy under the Standard Fertility Preservation Services section.

DEFINITIONS / ACRONYMS

DISORDERS OF SEX DEVELOPMENT (DSD): Refers to a group of medical conditions (i.e., Klinefelter Syndrome, Turner Syndrome, Androgen Insensitivity Syndrome, Congenital Adrenogenital Disorders, Congenital Adrenal Hyperplasia) in which anatomical, chromosomal, or gonadal sex varies in some way from what would be typically considered male or female. The *DSM*–5 criteria for gender dysphoria were revised to allow the diagnosis to be given to individuals with DSD.

EMANCIPATED MINOR: A minor (person who is not an adult) who is self-supporting and independent of parental control, usually as a result of court order (Cal. Fam. Code § 7122). Some examples are persons under the age of 18 who are married, or a minor who is on active duty with the armed forces (Cal. Fam. Code § 7002).

EUNUCH: People who are assigned male at birth (AMAB) and wish to eliminate masculine physical features, masculine genitals, or genital functioning. This also includes those whose testicles have been surgically removed or rendered nonfunctional by chemical or physical means and who identify as eunuch. This doesn't include men who have been treated for advanced prostate cancer and reject the designation of eunuch.

FEMALE TO MALE (FtM)
A person assigned female sex at birth and later adopts the identity, appearance, and gender role of a male, especially after gender confirmation surgery.

GENDER-AFFIRMING HEALTH CARE: means medically necessary health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to, the following:

- Interventions to suppress the development of endogenous secondary sex characteristics.
- Interventions to align the patient's appearance or physical body with the patient's gender identity; and
- Interventions to alleviate symptoms of mental health or substance use disorders resulting from gender dysphoria, as defined in the current Diagnostic and Statistical Manual of Mental Disorders.
- Interventions to align the patient's appearance or physical body with the patient's gender identity; and
- Interventions to alleviate symptoms of mental health or substance use disorders resulting from gender dysphoria, as defined in the current Diagnostic and Statistical Manual of Mental Disorders.

GENDER DYSPHORIA:
DSM-5 defines gender dysphoria as the distress that may accompany incongruence between one's experienced or expressed gender and one's assigned gender at birth. Gender dysphoria is treated as a developmental abnormality for purposes of the reconstructive statute and normal appearance is to be determined by referencing the gender with which the member identifies **(Health and Safety Code 1367.63(c)(1)(B)).** Gender non-conformity is not in itself a mental disorder.

GENDER DYSPHORIA/ INCONGREUENCEIN IN CHILDREN[5]
A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion 1):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender, different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing

[5] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.

only typical masculine clothing and a strong resistance to wearing of typical feminine clothing.

- A strong preference for cross-gender roles in make-believe play of fantasy play.
- A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough and tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

GENDER DYSPHORIA/ GENDER INCONGREUENCE IN ADOLESCENTS AND ADULTS[6]

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:
    1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (on in young adolescents, the anticipated secondary sex characteristics).
    2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (on in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    3. A strong desire for the primary and /or secondary sex characteristics of the other gender.
    4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if there is a DSD that is also relevant. Coding note: Code the disorder of sex development as well as gender dysphoria/ gender incongruence.

GENDER NON-BINARY

Non-binary or gender queer is a spectrum of gender identities that are not exclusively masculine or feminine—identities that are outside the gender binary. Non-binary identities can fall under the transgender umbrella, since many non-binary people identify with a

[6] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.

gender that is different from their assigned sex. The term nonbinary includes people whose genders are comprised of more than one gender identity simultaneously or at different times (e.g., bigender), who do not have a gender identity or have a neutral gender identity (e.g., agender or neutrois), have gender identities that encompass or blend elements of other genders (e.g., polygender, demiboy, demigirl), and/or who have a gender that changes over time (e.g., genderfluid)

IATROGENIC INFERTILTY
Infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

MALE TO FEMALE (MtF)
A person assigned male at birth and later adopts the identity, appearance, and gender role of a female, especially after gender confirmation surgery.

MEDICAL NECESSITY

- Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. **(Title 22 California Code of Regulations §51303).**
- For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. **(Welfare and Institutions Code section 14059.5.)**
- For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service corrects or ameliorates defects and physical and mental illnesses and conditions. **(Title 42 USC 1396d(r)(5)).**
- “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:
    - In accordance with the current generally accepted standards of mental health and substance use disorder care.
    - Clinically appropriate in terms of type, frequency, extent, site, and duration.
    - 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 provide **(Health and Safety Code section 1374.72 (3) (A)).**

MINOR SERVICES: California state law permits minors of any age to consent to/receive certain services. Please refer to Sections 5 "California Minor Consent Services.

POST TRANSITION

The individual has transitioned to full-time living in the desired identity-congruent gender role (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen- namely regular cross-sex treatment or gender reassignment surgery confirming the desired gender (e.g., appendectomy, vaginoplasty in the natal male; mastectomy or phalloplasty in the natal female). This ensures treatment access for individuals who continue to undergo hormone therapy, related surgery, or psychotherapy or counseling to support their gender transition.

QUALIFIED MENTAL HEALTH PROFESSIONAL

The mental health professional must have appropriate training:

- Have a Master's degree or, equivalent or higher, in a clinical mental science field (such as social work, psychology or marriage and family therapist) and licensed by their statutory body and hold, at a minimum a master's degree or equivalent training in a clinical field relevant to their role and granted by a nationally accredited statutory institution
- Have an up-to-date clinical license in the State of California.
- Able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Training, continuing education, and experience working with the diagnosis and treatment of gender incongruence/ gender dysphoria.
- Engagement with or liaise other health care professionals from different disciplines within the field of transgender health for consultation and referral, as needed.

QUALIFIED MEDICAL PROFESSIONAL

- The medical professional must have appropriate training and licensed to by their statutory body and hold, at a minimum a master's degree or equivalent training in a clinical field relevant to their role and granted by a nationally accredited statutory institution Have an up-to-date clinical license in the State of California.
- Able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Training, continuing education, and experience working with the diagnosis and treatment of gender incongruence/ gender dysphoria.
- Engagement with or liaise other health care professionals from different disciplines within the field of transgender health for consultation and referral, as needed.

RECONSTRUCTIVE SURGERY

In this document, procedures are considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, and trauma, treatment of a disease or congenital defect, or to treat gender dysphoria/incongruence. Reconstructive surgery is performed to correct or repair abnormal structures of the body caused by

congenital defects, development abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible. **(Health and Safety Code 1367.63).**

TRANSGENDER AND GENDER DIVERSE (TGD) PEOPLE: A broad and comprehensive as possible phrase in describing members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth. May include non-binary, eunuchs, and other non-confirming gender identities.

STANDARD FERTILITY PRESERVATION SERVICES
Procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CMP-015 Minor Consent to Medical Care

CMP-008 Members Rights to Release PHI

G&A-008 Adverse Benefit Determination Appeals Process

RX-002 PA Review Process

RX-003 Exception Review Process

RX-004 Formulary Management

UM-001 Utilization Management Program

UM-012 Care Coordination-Behavioral Health

UM-062 Behavioral Health Treatment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2013, 11/15/2018, 10/29/2020, 12/14/2020, 1/21/21, 05/20/2021, 08/24/2021, 4/27/2022, 6/28/22, 9/27/2022, 02/21/2023, 6/20/2023, 10/19/2023

REFERENCES

DHCS: All Plan Letter [APL] 20-018: Ensuring Access to Transgender Services

DHCS Provider Manual, Family Planning, August 2020.

DMHC All Plan Letter [APL] 20-002: Implementation of SB 855, MH.SUD Coverage

State Laws:

Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020). Section 1374.551. (a)

Insurance Gender Nondiscrimination Act - Health & Safety Code § 1365.5
Civil Rights Protections - Govt. Code § 11135
Department of Fair Employment and Housing Definitions -Govt. Code § 12926 (r)(2)
DMHC Director's Letter 12-K Gender Nondiscrimination Requirements

Federal Laws:

Nondiscrimination in Health Programs or Activities Receiving FFA or Administered by DHHS Under Title I of the ACA - 45 CFR §§ 92.206, 92.207
Section 1557 of the ACA - 42 USC § 18116

National Oranizations:

WPATH [World Professional Association for Transgender Health] Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, 2022.

Adelson SL, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. J Am Acad Child Adolesc Psychiatry. 2012; 51(9):957-974. Summary on National Guideline Clearinghouse [website].

American Psychiatric Association (APA). Gender Identity Disorder. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: American Psychiatric Association; 2000.

Publications:

American Psychological Association. (2015). Guidelines for professional practice with transgender and gender non-conforming people. American Psychologist, 70(9), 832–864.

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer III, W. J., Spack, N. P., Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. Journal of Clinical Endocrinology & Metabolism, 94(9), 3132– 3154. doi:10.1210/jc.2009–0345

Telfer, M. M., Tollit, M. A., Pace, C. C., & Pang, K. C. (2018). Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents. Medical Journal of Australia, 209(3), 132–136.

MONITORING

Annual audit based on CPT codes submitted.

POLICY AND PROCEDURE

Policy Number	UM-063
Policy Name	Gender Affirmation Surgery and Services
Department Name	Health Care Services-Utilization Management
Policy Owner	Medical Director of Utilization Management
Line(s) of Business	Medi-Cal and Group Care
Effective Date	11/21/2013
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	~~8/18/2023~~1/26/2024
Compliance Committee Approval Date	TBD~~10/19/2023~~

POLICY STATEMENT

Alameda Alliance for Health (the "Alliance") covers gender affirming medically necessary care for transgender and gender diverse members~~.~~, consistent with the ~~State Medi-Cal benefit **APL 20-018,** and following the~~ World Professional Association of Transgender Health (WPATH) Standard of Care for Transgender and Gender Nonconforming People for Group Care and Medi-Cal. Gender affirming medically necessary care for Medi-Cal members is consistent with the State Medi-Cal benefit **APL 20-018**.

1. The Alliance provides medically necessary covered services to all Medi-Cal beneficiaries and Group Care enrollees, including transgender diverse (TGD) beneficiaries Gender diverse people includes but is not exhaustive to include non-binary, eunuch, and intersex individuals.
2. Medically necessary covered services are those services:
   a. Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. **(Title 22 California Code of Regulations §51303).**
   b. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. **(Welfare and Institutions Code section 14059.5.)**
   c. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. **(Title 42 USC 1396d(r)(5)).**

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d. "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 current 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 provide **(Health and Safety Code section 1374.72 (3) (A)).**

3. The Alliance considers the following treatment medically necessary for all Members with gender dysphoria/gender incongruence:
   a. Mental health services, including psychotherapy;
   b. Gender affirmation (GA) feminizing/masculinizing hormone therapy and/or puberty blocker hormone therapy with clinical monitoring for efficacy and adverse events;
   c. GA surgery that is not strictly cosmetic in nature but addresses gender dysphoria/incongruence and/ or reconstructive services.
4. The Alliance must provide medically necessary reconstructive surgery to all Medi-Cal beneficiaries, including TGD beneficiaries. Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) to improve function. (B) to create a normal appearance, to the extent possible" **(Health and Safety Code § 1367.63m (c) (1) (A) (B)).**
5. In analyzing GA medical and surgical service requests, the Alliance must analyze GA requests under both the applicable medical necessity standard for services to treat gender dysphoria/incongruence and under the statutory criteria for reconstructive surgery. A finding of either "medically necessary to treat gender dysphoria" or "meets the statutory criteria of reconstructive surgery" serves as a separate basis for approving the request.
6. If the Alliance determines that the service is medically necessary to treat the member's gender dysphoria/incongruence, the Alliance must approve the requested service. If the Alliance determines the service is not medically necessary to treat gender dysphoria/incongruence (or if there is insufficient information to establish medical necessity), the Alliance must still consider whether the requested service meets the criteria for reconstructive surgery, taking into consideration the gender with which the member identifies.
7. The request for transgender services should be supported by evidence of either medical necessity or evidence supporting the criteria for reconstructive surgery. Supporting documentation should be submitted, as appropriate, by the member's primary care provider ("PCP"), licensed mental health professional, and/or surgeon. These providers should be qualified and have experience in transgender health care.
8. The Alliance will cover medically necessary medications to treat gender dysphoria/incongruence,, mental health or substance use disorders.

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9. The Alliance is required to treat beneficiaries consistent with their gender identity **(Title 42 United States Code §18116; 45 Code of Federal Regulations (CFR) §§92.206, 92.207; see also 45 CFR § 156.125).**
10. Federal regulations prohibit the Alliance from denying or limiting coverage of any health care services that are ordinarily or exclusively available to beneficiaries of one gender, to a TGD beneficiary based on the fact that a beneficiary's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available **(45 CFR §§92.206, 92.207 (b) (3)).**
11. DHCS indicates that Federal regulations further prohibits the Alliance from categorically excluding or limiting coverage for health care services related to gender **transition (45 CFR §92.207 (b) (4)).**
12. The Insurance Gender Nondiscrimination Act ("IGNA") prohibits the Alliance from discriminating against individuals based on gender, including gender identity or gender expression **(Health and Safety Code section § 1365.5).** The IGNA requires that the Alliance provide transgender beneficiaries with the same level of health care benefits available to non-transgender beneficiaries.
13. The Alliance may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive surgery determination, and/or apply appropriate utilization management criteria that are non-discriminatory. The Alliance may not categorically exclude health care services related to gender transition on the basis that it excludes those services for all members.
14. The Alliance must not categorically limit a service or the frequency of services available to a TGD member. For example, classifying certain services, such as facial feminization surgery as always "cosmetic" or "not medically necessary for any Medi-Cal member" is an impermissible "categorical exclusion" of the service. The Alliance must consider each requested service on a case-by-case basis and determine whether the requested service is either "medically necessary to treat the member's gender dysphoria" or meets the statutory definition of "reconstructive surgery."
15. In the case of TGD beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies (target gender).
16. 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 gender dysphoria/incongruence then it would be medically necessary.

PROCEDURE

Gender dysphoria (defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5) is treated with the following core services:

- Behavioral health services;
- Psychotherapy;

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- GA feminizing/ masculinizing hormone ~~therapy~~ and/or puberty blocker hormone therapy with clinical monitoring for efficacy and adverse events;
- Surgical and GA procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender, which is not strictly cosmetic in nature. Sex reassignment surgery (also known as GA surgery), is a treatment option for TGD beneficiaries.

People with gender dysphoria/ incongruence often report a feeling of being born into the wrong sex. Sex reassignment is not a single surgical procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual to achieve successful behavioral and medical outcomes.

Before undertaking sex reassignment surgery, important medical and mental health assessments should be undertaken to confirm that surgery is the most appropriate treatment choice for the individual.

Clinical guidance for the medical treatment of gender dysphoria is provided by the World Professional Association for Transgender Health (WPATH) 202211,~~-~~ Standards of Care ~~(SOC)~~ for the Health of Transsexual, Transgender, and Gender Nonconforming People [8~~7~~th Version]. https://doi.org/10.1080/26895269.2022.2100644. ~~https://www.wpath.org/publications/soc~~ The WPATH Standards of Care~~OC~~ falls under the UM 001 Hierarchy for Regulatory and Contractual Requirements for national specialty guidelines. Clinical guidance for the treatment of Substance Abuse Disorder is provided by American Society of Addiction Medicine, ASAM Criteria, 4~~3~~th~~rd~~ edition (20213). Clinical guidance for mental health disorders (age 18 or older) is provided by the American Association of Community Psychiatrist, Level of Care Utilization Systems (LOCUS), Version 20. Clinical guidance for the treatment of mental health disorders (age 6-17 years) is provided by the American Association of Community Psychiatrist, Child, and Adolescent Level of Care Utilization System (CALOCUS), Version 20; or the American Academy ~~of~~ of Child and Adolescent Psychiatry, the Child and Adolescent Level of Care/Service Intensity Instrument (CALOCUS-CASII). Edition 1.2 (2020)~~Child and Adolescent Psychiatry, Child, and Adolescent Service Intensity Instrument (CASII) 2019~~. Clinical guidance for the treatment of mental health disorders (ages 0-5 years) is provided by the American Academy of Child and Adolescent Psychiatry, Early Childhood Service Intensity Instrument (ESCII).

The medical appropriateness of surgical services requested by a TGD beneficiary must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the beneficiary's primary care provider or specialist; often it is a multidisciplinary team involved their care**.** The medical necessity and determination of a surgical procedure GA related or as reconstructive will be made by the Managed Care Plan.

I. Assess, Diagnose, and Discuss Treatment Options for Mental Health or Medical Conditions

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Clients presenting with gender dysphoria/incongruence may have underlying mental health or medical conditions. This could include unique anatomical, social, psychosocial, and medical comorbidity considerations. Multidisciplinary teams including a mental health professional, GA specialist and/ or surgeon, other specialists, and PCP are often involved. Adolescents uniquely will need a biopsychosocial assessment before proceeding with GA medical or surgical interventions.

~~II. Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):~~

~~a. *Fully reversible interventions.* These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.~~

~~b. *Partially reversible interventions.* These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).~~

~~c. *Irreversible interventions.* These are typically surgical procedures.~~

Although not an explicit criterion, a staged process that is defined by a surgeon in coordination with the member, is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions. New assessments and letters for each GA procedure are not required; multi-staged procedures do not require new mental health reapprovals. The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

~~**Irreversible Interventions**~~

~~Genital surgery should not be carried out until (i) gender dysphoria/incongruence is marked and sustained, (ii) meet diagnostic criteria, (iii) demonstrate emotional and cognitive maturity to provide informed consent (iv) mental health concerns are addressed and potential interference in their treatments; (v) informed discussion about reproductive effects from treatment; (vi) TGD member has reached Tanner stage 2. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.~~

The intent of this suggested sequence is to give adolescents and adults sufficient opportunity to experience and socially adjust to the new gender role and achieve the desire optimal hormonal result. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression. It is recommended that health care professionals maintain an

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ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment and hormonal treatment until the transition is made to adult care.

~~III.~~II. Written Assessment to Support Gender Affirming Hormone Therapy or Surgical Procedures. (1 Letter/ Documentation)

One written documentation or letter is required from a qualified health professional who has competency in the assessment of TGD people, to recommend for medical or surgical treatment. Thi~~, thi~~s can be a single letter that summarizes the single opinion for medically necessary ~~TG~~ GA treatment. ~~This health care professional must have competency in the assessment of TGD people.~~

Adolescents will additionally need a comprehensive biopsychosocial assessment: including input from relevant mental health and medical professionals. Involvement of parents(s)/ guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible[1]. A single letter from the adolescent's multidisciplinary team is needed and this letter can summarize the assessment and opinion from the team or single provider involving both medical and mental health professionals (American Psychological Association, 2015; Hembree et al., 2017; Telfer ~~et al.~~et al., 2018). It is recommended but not required for the health care professional to liaise with multidisciplinary trans health professionals who are from different disciplines within the field of trans health.

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Although not explicit criteria, the recommended content of the letter for GA hormone therapy or surgical intervention from a health care professional who has competency in the assessment of TGD people is as follows:

- The client's general identifying characteristics
- An explanation that the criteria for GA hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy
- Results of the members' psychosocial assessment (if applicable), including review of any medical or mental health diagnoses that may negatively interfere with the proposed GA treatments; risks and benefits were discussed before a treatment decision is made
- The duration of the referring health professional's relationship with the client, including the type of evaluation, therapy, or counseling to date
- A statement that informed consent has been obtained from the member or parent/ guardian.

[1] This includes people who were declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions. A parent/guardian signature is not required in the case of emancipated minors. (Cal. Fam. Code § 7122); (Cal. Fam. Code § 7002).

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- A statement that the referring health professional is available for coordination of care before and after interventions are initiated and for the duration of hormonal therapy

An assessment and psychosocial interventions for ~~children and~~ adolescents are often provided within a multidisciplinary gender identity specialty service. For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the member's chart as a comprehensive assessment. Although not explicit criteria, if such a multidisciplinary service is not available, then the health plan recommends that a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist[2] for the purpose of assessment, education, and involvement in any GA decisions.

~~**Although not explicit criteria, the recommended content of the referral letter for GA surgery who has competency in the assessment of TGD people is as follows:**~~

1. ~~The client's general identifying characteristics~~
1. ~~An explanation that the medical necessity criteria for surgery have been met, and a brief description of the clinical rationale for supporting the member's request for surgery~~
2. ~~Results of the members' psychosocial assessment (if applicable), including review of any medical or mental health diagnoses that may negatively interfere with the proposed GA treatments; risks and benefits were discussed before a treatment decision is made~~
3. ~~The duration of the referring health professional's relationship with the client, including the type of evaluation, therapy or counseling to date~~
4. ~~A statement that informed consent has been obtained from the member~~
5. ~~A statement that the referring health professional is available for coordination of care before and after interventions are initiated and for the duration of hormonal therapy~~

If the GA surgeries are staged a single letter that outlines multiple staged interventions is also acceptable. The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

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~~IV.~~III. Eligibility Criteria for Gender-Affirming Hormone Therapy or Puberty Blocker Hormones for ~~Children~~Adolescents (<~~under age~~ 18 Years Old)

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[2] If puberty blockers or gender-affirming hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone prescribing provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

Feminizing/ masculinizing hormone therapy (or puberty blockers) may lead to irreversible physical changes. ~~For the Alliance to approve hormone therapy members under 18 must meet ALL~~ All of the criteria below must be met:

1. Gender dysphoria/ gender incongruence is marked and sustained.
2. Meets the criteria for diagnostic criteria for gender dysphoria/ gender incongruence;
3. Demonstrates the emotional and cognitive maturity required to provide informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives[3].
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and GA medical treatments have been addressed; sufficient so that GA medical treatments can be provided optimally;
5. The adolescent has been informed of the reproductive effects, including potential loss of fertility and options for fertility preservation, and the context of the adolescent's stage of puberty development;
6. The adolescent has reached Tanner stage 2 ~~of puberty for pubertal suppression or hormone treatments.~~

~~V.~~IV. Eligibility Criteria Gender Affirming Hormone Therapy for Adults ~~over~~ (≥ ~~-~~18 Yyears Oold)~~.~~

~~Two goals justify intervention with gender-affirming hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.~~

A~~l~~ll~~L~~ of the following criteria must be met:

1. Gender dysphoria/ gender incongruence is marked and sustained;
2. Meets diagnostic criteria for gender dysphoria/ gender incongruence prior to initiating GA hormone treatment;

~~3. Other possible causes of apparent gender dysphoria/ gender incongruence have been identified and excluded;~~

~~4.~~3. ~~The member has signed informed consent, documenting capacity to make an informed decision~~Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;

[3] This includes people who were declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions. A parent/guardian signature is not required in the case of emancipated minors. (Cal. Fam. Code § 7122); (Cal. Fam. Code § 7002).

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4. Other possible causes of apparent gender dysphoria/ gender incongruence have been identified and excluded;
5. Mental health and physical conditions that could negatively impact the outcome of the treatment have been assessed, with risks and benefits discussed;
6. Understands the effects of GA hormone treatment on reproduction and they have explored reproductive options.

V. ~~VI.~~ Gender Affirmation Surgery

A. Eligibility Criteria for Gender Affirmation Surgery in Adolescents (< 18 Years Old)

For adolescents undergoing GA surgery, the procedure is medically necessary when all of the following criteria are met (1 through 8):

1. Gender dysphoria/ gender incongruence is marked and sustained;
2. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
3. Demonstrates the emotional and cognitive maturity required to provider informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives;
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and GA medical treatments have been addressed; sufficient so that GA medical treatments can be provided optimally;
5. Informed of the reproductive effects, including potential loss of fertility and the available options to preserve fertility;
6. At least 12 months of GA hormone therapy or longer, if required, to achieve the desired surgical result for GA procedures, including breast growth and skin expansion prior to breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty (with or without scrotoplasty), and facial surgery as part of GA treatment unless hormone therapy is either not desired or is medically contraindicated.

~~Eligibility Criteria for Gender Affirmation Surgery~~

B. ~~C.~~ Gender Affirming Surgery in Adults (≥ 18 Years Old)

For ~~individuals~~ adults undergoing GA surgery, the procedure is medically necessary when all of the following criteria are met (1 through ~~7~~8):

~~1. Member is 18 years old or older;~~
1. Gender dysphoria/ gender incongruence is marked and persistent;
2. Meets diagnostic criteria for gender incongruence prior to GA surgery interventions;

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3. Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;
~~3. The individual has capacity to make informed decisions and consent for the specific surgical intervention;~~
4. Understands the effect of ~~gender-affirming~~GA surgical intervention on reproduction and they have explored reproductive options;
5. Other possible causes of apparent gender dysphoria/ incongruence have been identified and excluded;
6. Mental health and physical conditions that could negatively impact the outcome of ~~gender-affirming~~GA surgical intervention have been assessed, and risks and benefits have been discussed;~~.~~
7. ~~Both mental health and medical professionals have been involved in the decision-making process.~~ Stable on their GA hormonal treatment regimen (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).

If requesting a GA gonadectomy surgery (~~i.e.~~i.e., Hysterectomy and/or salpingo-oophorectomy, or orchiectomy) ~~the following additional criteria is required~~although not an explicit criterion, it is recommended that~~: (1-8, 9):~~

- ~~9.~~ The member has tolerated a minimum of 6 months ~~or longer~~ of hormonal therapy (or longer period if required to achieve the desired surgical result) ~~as appropriate to achieve the desired surgical result~~, unless hormones are not clinically indicated, not desired, or~~it is~~ medically contraindicated ~~or not desired~~[4].

~~**If requesting genital procedures** (i.e. metoidioplasty (including placement of testicular prosthesis), phalloplasty (including placement of testicular/ penile prosthetics), vulvectomy, vulvoplasty, vaginoplasty, penectomy, perinoplasty, clitoroplasty, colpoclesis, labiaplasty, vaginectomy, scrotectomy, scrotoplasty, slit meatoplasty, urethroplasty, or placement of testicular prostheses) the following additional criteria is required: (1-8, 9):~~

~~10. The member has been stable on their current treatment regime (which may include at least 6 months of hormone treatment or a longer period if required[5]) to achieve the desired surgical result, unless hormone therapy is either medically contraindicated or not desired.~~

These criteria do not apply to members who are having these surgical procedures for medical indications other than gender dysphoria/ gender incongruence.

[4] The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention.
[5] ~~Longer hormone therapy may be required for sufficient clitoral virilization prior to metoidioplasty/ phalloplasty.~~

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~~Although not an explicit criterion, it is recommended that:.~~

~~a) There is a multidisciplinary team of professionals in the field of transgender health when TGD people request individually customized (previously termed "non-standard") surgeries as part of a gender-affirming surgical intervention.~~

~~a) If requesting a breast augmentation or mastectomy, it is recommended that the surgeon assess for risk factors associated with breast cancer prior to breast augmentation or mastectomy.~~

~~b) Surgeons caring for transgender men and gender diverse people who have undergone metoidioplasty /phalloplasty encourage lifelong urological follow-up.~~

~~c) Surgeons caring for transgender women and gender diverse people who have undergone vaginoplasty encourage follow-up with their primary surgeon, primary care physician, or gynecologist.~~

D. FACIAL FEMINIZATION SURGERY & VOICE AND COMMUNICATION THERAPY

Facial feminization surgery (including chondrolaryngoplasty/ vocal cord surgery) is considered a medically necessary to correct a significant physical functional impairment related to treating gender dysphoria/ gender incongruence, and/ or improve the physical functional impairment respectively. Examples include, but are not limited to, reconstructive procedures which correct or improve a significant functional impairment of speech, such as voice feminization/ modification surgery, nutrition, control of secretions, protection of the airway, or corneal protection. The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's request for facial reconstruction surgery. **All basic GA surgery criteria must be met (1-7~~8~~).**

Facial feminization surgery is considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, trauma, or treatment of a disease or congenital defect, or to treat gender dysphoria/ gender incongruence. Facial feminization surgery is considered not medically necessary when performed strictly to alter or reshape normal structures of the body in order to improve appearance (cosmetic in nature).

Note: The initial restoration may be completed in stages. New mental health assessments and letters are not required for each staged GA procedure; they do not require reapproval.

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Voice feminization surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective. All basic GA surgery criteria must be met (1-7~~8~~).

Although not explicit criterion, it is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication.

These criteria do not apply to members who are having these surgical procedures for medical indications other than gender dysphoria/ gender incongruence, or physical functional impairment/ physical reconstruction.

Voice and communication therapy may be medically necessary to treat gender dysphoria/incongruence, or to help individuals develop verbal (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication skills (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity through individual and/or group sessions, and to prevent the possibility of vocal misuse and long-term vocal damage. Therapy is conducted with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/ speech-language pathologists. These pre and post interventions may be needed after voice surgery, or testosterone therapy.

For the following GA reconstructive procedures: ~~(#1-8)~~

All basic GA surgery criteria must be met (1-7). Additionally, they are medically necessary if they treat gender dysphoria/incongruence, or to treat physical functional impairment/ physical reconstruction. The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's requested facial reconstruction surgery.

1. **Blepharoplasty, Blepharoptosis Repair, and Brow Lift**
   Upper eyelid blepharoplasty or blepharoptosis repair is considered medically necessary for ANY of the following conditions.

2. To treat gender dysphoria/gender incongruence;

a. Difficulty tolerating a prosthesis in an ophthalmic socket; or
b. Repair of a functional defect caused by trauma, tumor, or surgery; or
c. Periorbital sequelae of thyroid disease; or
d. Nerve palsy

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Note: For cases where combined procedures (for example, blepharoplasty and brow lift) are requested, the individual must meet the criteria for each procedure.

3. Blepharoplasty

Unilateral or bilateral upper eyelid blepharoplasty is considered medically necessary to relieve obstruction of central vision when the following criteria are met (a~~,~~ or b, and c-d):

a. To treat gender dysphoria/gender incongruence; or

b. Documented complaints of interference with vision or visual field-related activities causing significant functional impact such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin; and

c. There is either redundant skin overhanging the upper eyelid margin and resting on the eyelashes or significant dermatitis on the upper eyelid caused by redundant tissue; and

d. Prior to manual elevation of redundant upper eyelid skin (taping), the superior visual field is:

1) less than or equal to 20 degrees, or there is a 30 percent loss of upper field of vision compared to normal; and

2. Manual elevation (taping) of the redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

4. Eye Lid Surgery (Blepharoptosis Repair)

Blepharoptosis repair is considered medically necessary to relieve obstruction of central vision when the following criteria are met (a~~,~~ or b, c through ~~-~~e):

a. To treat gender dysphoria/gender incongruence; or

b. Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to eyelid position; and

c. Photographs taken with the camera at eye level and the individual looking straight ahead, document the abnormal lid position (photos should be submitted for review); and

d. Prior to manual elevation of the upper eyelid and redundant upper eyelid skin (taping), the superior visual field is a) less than or equal to 20 degrees or b) there is a 30 percent loss of upper field of vision compared to normal, or c) the margin reflex distance between the pupillary light reflex and the upper eyelid skin edge is less than or equal to 2.0 mm; and

e. Manual elevation (taping) of the upper eyelid and redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

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5. Brow Lift

Brow lift (that is, repair of brow ptosis due to laxity of the forehead muscles) is considered medically necessary when the following criteria are met (a~~,~~ or ~~b,~~ ~~and~~b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. Brow ptosis is causing a functional impairment of upper/outer visual fields with documented complaints of interference with vision or visual field related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin; and

c. Photographs show the eyebrow below the supraorbital rim.

Blepharoplasty, blepharoptosis repair, or brow lift for visual field defects is considered not medically necessary when the criteria noted above are not met.

- Blepharoplasty, blepharoptosis repair, or brow lift is considered not medically necessary when performed strictly to alter or reshape normal structures of the body in order to improve appearance.

- Lower lid blepharoplasty is considered not medically necessary.

- Blepharoplasty, blepharoptosis repair or brow lift procedures which are intended to correct a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect are considered reconstructive in nature, or there is a medical need to treat gender dysphoria/gender incongruence**.**

6. Otoplasty

Otoplasty is considered medically necessary when performed to surgically correct a physical structure or absence of a physical structure that is causing hearing loss, or intended to facilitate the use of a hearing aid or device when both of the following criteria are met (a~~,~~ or b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. The procedure is reasonably expected to improve the physical functional impairment; and

c. An audiogram documents a loss of at least 15 decibels in the affected ear(s).

Otoplasty is considered reconstructive when intended to restore a significantly abnormal external ear or auditory canal related to accidental injury, disease, trauma, or treatment of a disease or congenital defect, or there is a medical need to treat gender dysphoria/gender incongruence**.**

Otoplasty is considered reconstructive when intended to restore the absence of the external ear due to accidental injury, disease, trauma, or the treatment of a

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disease or congenital defect, or there is a medical need to treat gender dysphoria/gender incongruence**.**

Otoplasty is considered not medically necessary when performed strictly to alter or reshape normal structures of the body to improve appearance. Examples include, but are not limited to, repair of ear lobes with clefts or other consequences of ear piercing, or protruding ears.

Otoplasty is considered not medically necessary when the gender dysphoria/gender incongruence, or medically necessary reconstructive criteria in this section are not met.

7. Nasal Procedures - Rhinoplasty or rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)

Rhinoplasty is considered medically necessary when both of the following criteria are met (a~~,~~ or b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. The medical record documentation includes evidence of the failure of conservative medical therapy for severe airway obstruction from deformities due to disease, structural abnormality, or previous therapeutic process that will not respond to septoplasty alone; and

c. The procedure can be reasonably expected to improve the physical functional impairment;

- Rhinoseptoplasty is considered medically necessary when gender dysphoria/gender incongruence, or the criteria above for rhinoplasty are met and medically necessary criteria in MCG guideline ACG: A-0182 Septoplasty are also met.

- Rhinoplasty is considered reconstructive if there is documented evidence (that is, radiographs or appropriate imaging studies) of nasal fracture resulting in significant variation from normal without physical functional impairment, or to treat gender dysphoria/gender incongruence. The intent of the surgery is to correct the deformity caused by the nasal fracture.

- Rhinoseptoplasty is considered reconstructive if there is documented evidence (that is, radiographs or appropriate imaging studies) of nasal and septal fracture resulting in significant variation from normal without physical functional impairment, or to treat gender dysphoria/gender incongruence. The intent of the surgery is to correct the deformity caused by the nasal and septal fracture.

- Rhinoplasty or rhinoseptoplasty to modify the shape or size of the nose is considered not medically necessary when the gender dysphoria/gender

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incongruence medical necessity, or reconstructive criteria in this section are not met.

8. Face lift (Rhytidectomy)
Rhytidectomy is considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, and trauma, treatment of a disease or congenital defect, or to treat gender dysphoria/gender incongruence. Examples include, but are not limited to, significant burns or other significant major facial trauma.

Rhytidectomy is considered not medically necessary when the gender dysphoria/gender incongruence, or reconstructive criteria in this section are not met, including but not limited to, removal of wrinkles, excess skin, or to tighten facial muscles.

9. Hair Removal
Hair removal consultation is covered for the genital area when authorization is in place for gender GA surgery, or it is necessary intervention in preparation for surgery. Consultation is needed for the removal of body hair for feminization from the face, chest, back, abdomen, genitalia, arms, and legs if there is persistent gender dysphoria/ gender incongruence, or there is significant disruption of professional and/ or social life because of hirsutism with some medical evaluation outlining the psychological distress related to unwanted hair and justification of medical necessity. Other medical reasons may include if a hair loss response has not been noticed after one year of hormone treatment. Hair reduction procedures include:

(a) Laser Epilation/Hair Removal require:
- (i) to be provided by a physician, PA, NP, or RN (requires physician supervision);
- (ii) Informed consent;
- (iii) Documentation justifying laser hair removal for specific body areas

(b) Electrolysis Hair Removal require:
- (i) Documentation of consultation by a physician, PA, NP, or RN (requires physician supervision);
- (ii) Informed consent;
- (iii) Documentation justifying laser hair removal for specific body areas
- (iv) Justification as to why a trial of laser hair removal should not proceed electrolysis;
- (v) Electrolysis will be provided by a licensed electrologist.

E. Additional Procedures for Body Feminization or Body Masculinization
The following procedures are medically necessary when they are requested for the treatment of gender dysphoria/ gender incongruence, or reconstructive surgery (to

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correct or repair abnormal structures of the body to create a normal appearance for the target gender to the extent possible). All basic GA surgery criteria must also be met (1-~~7~~8). The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's requested surgical or reconstructive procedure.

- ~~-~~Abdominoplasty
- Body contouring (liposuction, lipofilling, Implants, monsplasty/ mons reduction)
-
- Cheek surgery
- Chin Shaping
- Facial bone reconstruction
- Gluteal augmentation
- Hair removal/ hairplasty, when the criteria above have not been met.
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Suction-assisted Lipoplasty/ trunk contouring
- Otoplasty
- Tattoo (i.e., nipple/ areol~~a~~ae)
-
- ~~-~~Penile prosthesis in the setting of proposed or completed phalloplasty
- Thyroid cartilage reduction/Tracheal shave feminization (larygeochondroplasty)
- Voice Modification Surgery

F. Revisions of Gender-Affirming Surgery (1 Letter Assessment)
The Alliance authorizes requests for surgical revision on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity to treat gender dysphoria/ gender incongruence and/or reconstructive surgery. Clinical documentation must support medical necessity to treat gender dysphoria/ gender incongruence or reconstructive surgery. Surgical revision requests require all of the following:

a. Medical and/or functional complications of prior ~~gender-affirming~~GA procedure;
b. Measurements and/or photographs of deformity/asymmetry (if applicable);
c. Members who regret their ~~gender-related~~GA surgical intervention are to be managed by an expert multidisciplinary team.
d. Endorsement of medical necessity or reconstructive purpose from the performing surgeon.

The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

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VI. Standard Fertility Preservation Services
For coverage options please refer to the UM-057 policy under the Standard Fertility Preservation Services section.

DEFINITIONS / ACRONYMS

DISORDERS OF SEX DEVELOPMENT (DSD): Refers to a group of medical conditions (i.e., Klinefelter Syndrome, Turner Syndrome, Androgen Insensitivity Syndrome, Congenital Adrenogenital Disorders, Congenital Adrenal Hyperplasia) in which anatomical, chromosomal, or gonadal sex varies in some way from what would be typically considered male or female. The *DSM*–5 criteria for gender dysphoria were revised to allow the diagnosis to be given to individuals with DSD.

EMANCIPATED MINOR: A minor (person who is not an adult) who is self-supporting and independent of parental control, usually as a result of court order (Cal. Fam. Code § 7122). Some examples are persons under the age of 18 who are married, or a minor who is on active duty with the armed forces (Cal. Fam. Code § 7002).

EUNUCH: People who are assigned male at birth (AMAB) and wish to eliminate masculine physical features, masculine genitals, or genital functioning. This also includes those whose testicles have been surgically removed or rendered nonfunctional by chemical or physical means and who identify as eunuch. This doesn't include men who have been treated for advanced prostate cancer and reject the designation of eunuch.

FEMALE TO MALE (FtM)
A person assigned female sex at birth and later adopts the identity, appearance, and gender role of a male, especially after gender confirmation surgery.

GENDER-AFFIRMING HEALTH CARE: means medically necessary health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to, the following:

- Interventions to suppress the development of endogenous secondary sex characteristics.
- Interventions to align the patient's appearance or physical body with the patient's gender identity; and
- Interventions to alleviate symptoms of mental health or substance use disorders resulting from gender dysphoria, as defined in the current Diagnostic and Statistical Manual of Mental Disorders.
- Interventions to align the patient's appearance or physical body with the patient's gender identity; and

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- Interventions to alleviate symptoms of mental health or substance use disorders resulting from gender dysphoria, as defined in the current Diagnostic and Statistical Manual of Mental Disorders.

GENDER DYSPHORIA:
DSM-5 defines gender dysphoria as the distress that may accompany incongruence between one's experienced or expressed gender and one's assigned gender at birth. Gender dysphoria is treated as a developmental abnormality for purposes of the reconstructive statute and normal appearance is to be determined by referencing the gender with which the member identifies **(Health and Safety Code 1367.63(c)(1)(B)).** Gender non-conformity is not in itself a mental disorder.

GENDER DYSPHORIA/ INCONGREUENCEIN IN CHILDREN[6]
A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion 1):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender, different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play of fantasy play.
- A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough and tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

GENDER DYSPHORIA/ GENDER INCONGREUENCE IN ADOLESCENTS AND ADULTS[7]

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:
    1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (on in young adolescents, the anticipated secondary sex characteristics).

[6] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.
[7] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.

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2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (on in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and /or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if there is a DSD that is also relevant. Coding note: Code the disorder of sex development as well as gender dysphoria/ gender incongruence.

GENDER NON-BINARY

Non-binary or gender queer is a spectrum of gender identities that are not exclusively masculine or feminine—identities that are outside the gender binary. Non-binary identities can fall under the transgender umbrella, since many non-binary people identify with a gender that is different from their assigned sex. The term nonbinary includes people whose genders are comprised of more than one gender identity simultaneously or at different times (e.g., bigender), who do not have a gender identity or have a neutral gender identity (e.g., agender or neutrois), have gender identities that encompass or blend elements of other genders (e.g., polygender, demiboy, demigirl), and/or who have a gender that changes over time (e.g., genderfluid)

IATROGENIC INFERTILTY

Infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

MALE TO FEMALE (MtF)

A person assigned male at birth and later adopts the identity, appearance, and gender role of a female, especially after gender confirmation surgery.

MEDICAL NECESSITY

- Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. **(Title 22 California Code of Regulations §51303).**
- For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant

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illness or significant disability, or to alleviate severe pain. **(Welfare and Institutions Code section 14059.5.)**

- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. **(Title 42 USC 1396d(r)(5)).**
- "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:
    - In accordance with the current generally accepted standards of mental health and substance use disorder care.
    - Clinically appropriate in terms of type, frequency, extent, site, and duration.
    - 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 provide **(Health and Safety Code section 1374.72 (3) (A)).**

MINOR SERVICES~~inor Services~~: California state law permits minors of any age to consent to/receive certain services. Please refer to Sections 5 "California Minor Consent Services.

POST TRANSITION

The individual has transitioned to full-time living in the desired identity-congruent gender role (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen- namely regular cross-sex treatment or gender reassignment surgery confirming the desired gender (e.g., appendectomy, vaginoplasty in the natal male; mastectomy or phalloplasty in the natal female). This ensures treatment access for individuals who continue to undergo hormone therapy, related surgery, or psychotherapy or counseling to support their gender transition.

QUALIFIED MENTAL HEALTH PROFESSIONAL

The mental health professional must have appropriate training:

- Have a Master's degree or, equivalent or higher, in a clinical mental science field (such as social work, psychology or marriage and family therapist) and licensed by their statutory body and hold, at a minimum a master's degree or equivalent training in a clinical field relevant to their role and granted by a nationally accredited statutory institution
- Have an up-to-date clinical license in the State of California.
- Able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.

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- Training, continuing education, and experience working with the diagnosis and treatment of gender incongruence/ gender dysphoria.
- Engagement with or liaise other health care professionals from different disciplines within the field of transgender health for consultation and referral, as needed.

QUALIFIED MEDICAL PROFESSIONAL

- The medical professional must have appropriate training and licensed to by their statutory body and hold, at a minimum a master's degree or equivalent training in a clinical field relevant to their role and granted by a nationally accredited statutory institution Have an up-to-date clinical license in the State of California.
- Able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Training, continuing education, and experience working with the diagnosis and treatment of gender incongruence/ gender dysphoria.
- Engagement with or liaise other health care professionals from different disciplines within the field of transgender health for consultation and referral, as needed.

RECONSTRUCTIVE SURGERY

In this document, procedures are considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, and trauma, treatment of a disease or congenital defect, or to treat gender dysphoria/incongruence. Reconstructive surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, development abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible. **(Health and Safety Code 1367.63).**

TRANSGENDER AND GENDER DIVERSE (TGD) PEOPLE: A broad and comprehensive as possible phrase in describing members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth. May include non-binary, eunuchs, and other non-confirming gender identities.

STANDARD FERTILITY PRESERVATION SERVICES

Procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

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RELATED POLICIES AND PROCEDURES

CMP-015 Minor Consent to Medical Care

CMP-008 Members Rights to Release PHI

G&A-008 Adverse Benefit Determination Appeals Process

RX-002 PA Review Process

RX-003 Exception Review Process

RX-004 Formulary Management

UM-001 Utilization Management Program

UM-012 Care Coordination-Behavioral Health

UM-062 Behavioral Health Treatment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2013, 11/15/2018, 10/29/2020, 12/14/2020, 1/21/21, 05/20/2021, 08/24/2021, 4/27/2022, 6/28/22, 9/27/2022, 02/21/2023, 6/20/2023, 10/19/2023

REFERENCES

DHCS: All Plan Letter [APL] 20-018: Ensuring Access to Transgender Services

DHCS Provider Manual, Family Planning, August 2020~~, page 1.~~.

DMHC All Plan Letter [APL] 20-002: Implementation of SB 855, MH.SUD Coverage

State Laws:

Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020). Section 1374.551. (a)

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Insurance Gender Nondiscrimination Act - Health & Safety Code § 1365.5
Civil Rights Protections - Govt. Code § 11135
Department of Fair Employment and Housing Definitions -Govt. Code § 12926 (r)(2)
DMHC Director's Letter 12-K Gender Nondiscrimination Requirements

Federal Laws:
Nondiscrimination in Health Programs or Activities Receiving FFA or Administered by DHHS Under Title I of the ACA - 45 CFR §§ 92.206, 92.207
Section 1557 of the ACA - 42 USC § 18116

National Oranizations:
WPATH [World Professional Association for Transgender Health] ~~STANDARDS~~ Standards of~~OF~~ Care~~ARE~~ for the Health of Transgender and Gender Diverse People, Version ~~8~~7, 2021~~21~~.

Adelson SL, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. J Am Acad Child Adolesc Psychiatry. 2012; 51(9):957-974. Summary on National Guideline Clearinghouse [website].

American Psychiatric Association (APA). Gender Identity Disorder. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: American Psychiatric Association; 2000.

Publications:

American Psychological Association. (2015). Guidelines for professional practice with transgender and gender non-conforming people. American Psychologist, 70(9), 832–864.

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer III, W. J., Spack, N. P., Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. Journal of Clinical Endocrinology & Metabolism, 94(9), 3132– 3154. doi:10.1210/jc.2009–0345

Telfer, M. M., Tollit, M. A., Pace, C. C., & Pang, K. C. (2018). Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents. Medical Journal of Australia, 209(3), 132–136.

MONITORING

Annual audit based on CPT codes submitted.

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ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM – 068
Policy Name	Tertiary and Quaternary Review Process
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	Medi-Cal, Group Care
Effective Date	01/21/2021
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health ("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

The Alliance maintains a network of providers that is supported by written agreement and is sufficient to provide adequate access to care. Tertiary and Quaternary care referrals are reviewed for the purpose of medical overview, preventing overtreatment, and to avoid unnecessary treatment that may result in lack of patient benefit and bear potential cause of harm.

Within the Alliance's network that delivers both tertiary and quaternary care includes the following National Cancer Institute (NCI) designated comprehensive Cancer Centers:

- University of California, San Francisco Helen Diller Family Comprehensive Cancer Center
- Stanford Cancer Institute, (includes Oncology and Bone Marrow Transplant (BMT) Services) and Major Organ Transplants (MOT)

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. For example, if the Member is in the midst of an active course of treatment for a medical or behavioral need, and 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. The Provider must be willing to accept rates with the health plan, be a registered MediCal provider, and not have documented quality of care concerns.
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. 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. Requests are reviewed and evaluated based upon individual medical or behavioral needs. The request may include the following specialty 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.

The Alliance considers the following requests to tertiary or quaternary centers as appropriate for potential redirection to community-based specialist:

1. Hematology/ Oncology consultation for cancers that by available documentation do **not** demonstrate advanced stages or metastasis, have not failed (or are deemed not likely to fail) standard care available in the community, and/or are not rare or aggressive cancer types. A complex cancer diagnosis on the other hand would support a referral to a tertiary or quaternary center.
2. Specialty requests for consultations when specialists with appropriate access standards that can provide equivalent services are available in the community.

3. 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.
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. Tertiary or quaternary care requests for continuity of treatment of stable Members in the maintenance phase of their medical condition. 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.

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) is sent to the member and requesting provider. The NOA 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 also includes the members' right to file an appeal of the determination. The Alliance's appeal process is outlined in policy and procedure *G&A-008 Adverse Benefit Determination Appeal Process*.

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

- 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, 1/19/2024

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.

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POLICY AND PROCEDURE

Policy Number	UM – 068
Policy Name	Tertiary and Quaternary Review Process
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management~~Sr. Director of Health Care Services~~
Line(s) of Business	Medi-Cal, Group Care
Effective Date	01/21/2021
Subcommittee Approval Date~~**Approval/Revision Date**~~	~~02/21/2023~~TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

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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~~high-quality outcomes.

PROCEDURE

The Alliance maintains a network of providers that is supported by written agreement and is sufficient to provide adequate access to care. Tertiary and Quaternary care referrals are reviewed for the purpose of medical overview, preventing overtreatment, and to avoid unnecessary treatment that may result in lack of patient benefit and bear potential cause of harm.

Within the Alliance's network that delivers both tertiary and quaternary care includes the following National Cancer Institute (NCI) designated comprehensive Cancer Centers:

- University of California, San Francisco ~~Medical Center~~Helen Diller Family Comprehensive Cancer Center
- Stanford ~~University Medical Center~~Cancer Institute, (~~only for~~includes Oncology and Bone Marrow Transplant (BMT) Services) and Major Organ Transplants (MOT)~~ and Bone Marrow Transplant (BMT) Services.)~~

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. For example, if the Member is in the midst of ~~management of an acute~~ an active course of treatment for a medical or behavioral need, and the Member has seen the tertiary or quaternary care provider within the last 12 months, referral authorization for continuity of care or ~~continued follow up~~active course of treatment would be indicated. The Provider must be willing to accept rates with ~~contract rates from~~ the health plan, be~~is~~ a registered MediCal provider, and not have documented quality of care concerns.
3. Referrals whose redirection may result in delay of necessary medical diagnostic services or treatment. Ancillary medical requests ~~(e.g.~~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 ~~continuity of care~~ there an active course of treatment exists. 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. Requests are reviewed and evaluated based upon individual medical or behavioral needs. The request may include the following specialty 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.

The Alliance considers the following requests to tertiary or quaternary centers as appropriate for potential redirection to community-based specialist:

1. Hematology/ Oncology consultation for cancers that by available documentation do **not** demonstrate advanced stages or metastasis, have not failed (or are deemed not likely to fail) standard care available in the community, and/or are not rare or aggressive cancer

types. A complex cancer diagnosis on the other hand would support a referral to a tertiary or quaternary center.
2. Specialty requests for consultations when specialists with appropriate access standards that can provide equivalent services are available in the community.
3. Tertiary or quaternary care center requests for ancillary services (~~e.g.~~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. Tertiary or quaternary care requests for ~~continued follow up~~continuity of treatment of stable Members in the maintenance phase of their medical condition. 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.

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) is sent to the member and requesting provider. The NOA 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 also includes the members' right to file an appeal of the determination. The Alliance's appeal process is outlined in policy and procedure *G&A-008 Adverse Benefit Determination Appeal Process*.

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.

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AFFECTED DEPARTMENTS/PARTIES

- Utilization Management Department

RELATED POLICIES AND PROCEDURES

- 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, 1/19/2024

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 ~~monthly~~ 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 ~~change~~changes to any applicable state regulation, and implementation of new or updated policy and

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procedures. ~~Trainings~~Training courses ~~are documented and require a signature of the participants involved.~~

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POLICY AND PROCEDURE TEMPLATE

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
Line(s) of Business	Medi-Cal and Group Care
Effective Date	11/23/2021
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	9/19/2023 *** (new compliance date)

POLICY STATEMENT

Alameda Alliance for Health (AAH) ensures appropriate utilization of all healthcare services for members in compliance with all applicable State and Federal regulations. 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 2/1/2023, 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. ~~It is designed to replace fingerstick blood glucose testing for diabetes treatment decisions as indicated in the FDA 2019 approval.~~ 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. ~~While Medi-Cal Rx currently does not provide CGMs for non-Type 1 diabetics, AAH and its delegates will provide CGMs with the criteria requirement of Type 2 diabetes OR Gestational Diabetes (non-Type 1).~~ 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. ~~M~~For Managed Care members who are not eligible for CGM under the Medicare criteria, they ~~but meet the AAH UM-069 CGM criteria will be reviewed for medical necessity following AAH's policy criteria.~~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.

~~**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 except for I. Alliance CGM Criteria # 3.~~

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.

[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)

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I. The Alliance CGM Criteria[4]

For ~~a~~n initial CGM authorization, ~~and~~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 ~~therapeutic~~ 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 ~~Type 2 diabetes mellitus, OR gestational diabetes not related to Type 1 diabetes; AND~~or either diabetes or gestational diabetes:
    - Diabetes (Type 1 or 2) and one of the following other criteria:
        - Insulin dependent based on regular insulin claim history in the past year or other documentation of regular insulin use: OR
        - 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.
    - Gestational Diabetes:
        - Restricted to approval for the duration of the pregnancy up to a maximum of 9 months; AND
        - Estimated date of delivery must be included in the request.

~~3.~~4. A HbA1c (A1C) value measured within eight (8) months must be documented on the PA request; AND

~~4. Is on an insulin treatment regimen that requires frequent adjustments of insulin dosing on the basis of self-monitoring blood glucose testing an average of three (3) times or more per day or continuous glucose monitoring testing results[5][6]; AND~~

~~5. To initiate therapy, has completed a comprehensive diabetes education program[7][8] or diabetes prevention program[9] within the last twelve (12) months; AND~~

~~6. To initiate therapy, the beneficiary and/or caregiver demonstrates the ability to understand and appropriately respond to information displayed on a therapeutic CGM receiver (monitor)[10]; AND~~

~~7. To initiate therapy, the beneficiary and/ or caregiver agrees the beneficiary will wear the therapeutic CGM at least five (5) days per week of use, or twenty (20) day of use per month[11]; AND~~

[4] Medi-Cal Rx Provider Manual, V1.1.0, October 1, 2023, Page 142, Accessed 10/27/2023, Medi-Cal Rx Provider Manual

~~[5] Review of Medi-Cal Rx Provider Manual Version 1.13, released May 1, 2022. https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf~~

~~[6] MCG 27th edition, Continuous Glucose Monitoring ACG: A-0126 (AC)~~

~~[7] Please refer to the American Diabetes Association website for more information on locating a local Diabetes Education program~~

~~[8] MCG 27th edition, Continuous Glucose Monitoring ACG: A-0126 (AC)~~

~~[9] Please refer to the DHCS website for information about locating a Diabetes Prevention Program~~

~~[10] MCG 26th edition, Continuous Glucose Monitoring ACG: A-0126 (AC)~~

~~[11] MCG 26th edition, Continuous Glucose Monitoring ACG: A-0126 (AC)~~

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8. Has been seen or evaluated by an endocrinologist or healthcare practitioner with experience in diabetes management and continuous subcutaneous insulin infusion therapy every six (6) months, either in person or virtually, to evaluate their diabetes control and ensure all of the criteria above are met[12]; AND
9. The initial PA period must not exceed 6 months, AND
10. A HbA1c (A1C) value measured within six (6) months must be documented on the PA request; AND
11. For beneficiaries residing in a Long Term Care (LTC) facility setting, clinical justification must be included and demonstrate why traditional use of a Self-Monitoring Blood Glucose Test System administered by licensed care staff and continuous medical support reimbursed by state or federal resources does not meet the patient's clinical needs.

II. **Reauthorization of CGM**

The prior authorization request must not exceed 12 months and must include the following documentation to support the following criteria[13]:

1. Has been seen and evaluated by the prescriber annually, either in person or virtually through video or telephone conferencing with documentation of:an endocrinologist or healthcare practitioner with experience in diabetes management and continuous subcutaneous insulin infusion therapy at least every 6 months, either in-person or virtually through video or telephone conferencing AND no more than three (3) months prior to submission of the reauthorization request. Visit summaries must accompany each request and should include a written narrative by the prescriber documenting that the beneficiary is doing the following:
    a. The date of the most recent visit; ANDUsing the device as prescribed[14]
    b. The member is using the device as prescribed; ANDDocumenting the number of days the CGM is worn
    c. The member is maintaining clinical hemoglobin A1C targets defined by the provider.Achieving or maintaining clinical targets where the prescriber defines the clinical targets and includes A1C values. Additional metrics may be included specific to the device such as Time in Range, mean glucose, or other analytics if readily retrievable; AND
2. Is on an insulin treatment regimen that requires frequent adjustments of insulin dosing on the basis of self-monitoring blood glucose testing an average of three (3) times or more per day or continuous glucose monitoring testing results[15]; AND
3. The beneficiary has been using the therapeutic CGM system as prescribed, wearing the CGM at least five (5) days per week of use or twenty (20) days of use per month; AND
4. The beneficiary has been able to improve or maintain glycemic control; or continues to use an external insulin pump; AND
5. HbA1C testing is required and documented at least every 6 months; AND

[12] LCD 33822 Glucose Monitors, updated 2/28/2022.
[13] Referencing Medi-Cal Rx Provider Manual Version 1.13, released May 1, 2022. https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf
[14] MCG 27th edition, Continuous Glucose Monitoring ACG: A-0126 (AC)
[15] MCG 27th edition, Continuous Glucose Monitoring ACG: A-0126 (AC)

6. For beneficiaries residing in a LTC facility setting, clinical justification must be included and demonstrate why traditional use of a Self-Monitoring Blood Glucose Test System administered by licensed care staff and continuous medical support reimbursed by state or federal resources does not meet the patient's clinical needs.

III. Life of the prior authorization approval calling CGM Limitations

CGM devices will not be considered reasonable and necessary for the following:

III.

1. CGM initial authorization and subsequent reauthorizations will be for initiate on the date of approval based supply. Individuals that do not require insulin therapy[16]
2. Non-therapeutic CGM
3. Short-term CGM (72 hours to 1 week) for diagnostic use[17]

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PROCEDURE

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**
Durable Medical Equipment (DME)/Incontinence	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**

For Prior Authorizations management by CHME

1. Initial Review
   - If a case meets the criteria requirement, CHME will process the request.
   - If the case does not meet criteria requirement or the requested service provider is a non-contracted provider then the request will be routed to AAH UM Department for review and dispensation.
     a. 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.

For PA requests routed to the Alliance:

[16] LCD 38743 Updated 3/4/2021. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=38743&ver=3&articleId=58277&bc=AAAAAAAAEAAA&

[17] LCD 38743 Updated 3/4/2021.

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) Member eligibility
    b) Completeness of the request
        i. Presence of the applicable medical codes, e.g. ICD-10, CPT, HCPC.
        ii. 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

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:

7. Final determination documentation
    - If a case meets medical necessity, MD Advisor will document the rationale, clinical decision making and the final determination.
    - 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.
    - 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.

8. The MD Advisor will route the PA to the UM Coordinator for final processing.

9. The UM Coordinator will complete the PA process as defined in UM policy UM-057 Authorization Service Requests and UM-054 Notice of Action.

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.

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

~~DHCS – Medical Supplies: Future Updates to CGM Systems Coverage Criteria and PA Bundling~~

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

CGM Workflow for Physicians and Medical Advisors

REVISION HISTORY

11/23/2021, 6/28/2022, 9/19/2023, ***

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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

MONITORING

Annually

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