ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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Quality Improvement Health Equity Committee Voting Items Policies & Procedures April 11, 2025

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

Policy Procedures Summary of Changes

Policy	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)
1	Health Education	HED-010	Doula Services	Describes how the Alliance offers Doula Benefit to eligible members.	Yearly updte and minor grammar edits.			X
2	Quality	QI-115	Access and Availability Committee	Describes how the Access and Availability (A&A) Committee provides oversight to ensure: 1) timely access to and availability of quality health care services for all members within the Alliance and delegate network, and 2) the continuous monitoring of access to and availability of behavioral and medical health care services in adherence with regulatory and contractual access and availability requirements.	MCARE/DSNP- CMS, Title 42. CFR 422.112 1) Ensures AAH monitor provider network adequacy, appointment wait time, and Geo Access 2)Address barriers to care, including SDOH and provider shortage 3) Interventions to improve access to care and reduce disparities	x		
3	Quality	QI-117	Member Satisfaction Survey (CAHPS)	The CAHPS survey is designed to solicit feedback from Alliance members about their experience/satisfaction with the Alliance as a health plan, with their health care and their perceived effectiveness of care	MCARE/DSNP-CMS Title 42, CFR Section 423.156 1)Ensure unbiased, standardized data collection using CMS approved Vendor 2) Identification of population with disparities (e.g racial/ethnic group, limited English proficiency, diability status) 3) Implement QI initiatives to address member satisfaction concerns	x		
4	Quality	QI-118	Provider Satisfaction Survey	The Provider Satisfaction Survey provides the Alliance with provider feedback about their experience with the Alliance.	MCARE/DSNP-CMS Title 42, CFR Section 422.202 (b) 1)Ensure Provider Satisfaction survey, conclusion and recommendations are incorporated into QIHE Program Work Plan for MediCal/ Alliance Health Wellness/Group Care, and annually reported to CMS	x		
5	UM	UM-015	Emergency Services and Post Stabilization Services	Discussed how post stabilization servives are managed in complaince with the DMHC APL	New Version- Significant updates to policy. Removed duplications and moved some of what was in policy statement section into the procedure section. Clarified the process for the Delegate distribution of the information if a call is received related to a delegated member. Changed HCQC to QIHEC. Clarified language describing staff availability 24/7	X		
6	UM	UM-025	Guidelines for Obstetrical Services	Describes the evidence-based, clinical practice guidelines used in the provision of obstetrical services	Added requirements for Maternal Mental Health Screenings, as described in AB No. 1936 (at least 1 during pregnancy and 1 additional during first 6 weeks postpartum, and additional postpartum screenings as per clinical judgement of treating provider) also recommending P&P to be transitioned to CM; will request Compliance assign a CM P&P number	X		

Policy Procedures Summary of Changes

7	UM	UM-053	Breastfeeding Lactation Management Aids	Describes process for obtaining breast pump and human donor milk	Updated policy to be inclusive of AB 3059 guidance which requires that effective January 1, 2025, all lines of business to cover the provision of medically necessary pasteurized donor human milk obtain from a tissue bank licensed pursuant to Chapter 4.1 (HSC) as a basic health care services.	X		
8	CMDM	CM-002	Complex Case Management Plan Development and Management	Care plan requirements for CCM cases	Remove CCM delegation language (no more Kaiser CCM). Update attachment 2, CCM welcome letter.	X		
9	CMDM	CM-003	Complex Case Management Plan Evaluation and Closure	Criteria to close out CCM care plan and close case	Remove CCM delegation language (no more Kaiser CCM). Clarify CM Satisfaction Survey.	X		
10	CMDM	CM-006	Internal Audit and Monitoring	Monitoring and auditing of all CM cases and HRA cases	2/28 UMC: Remove language realted to UM and pharmacy internal audits. Update description of schedule to align with monthly productivity and quality metrics. 3/28 UMC: Add language stating frequency of auditing for all CM cases including phone call monitoring.	X		
11	CMDM	CM-007	SPD High Risk Stratification and Care Planning	Identification and stratification of SPD members / Health Information Form/Member Evaluation Tool (HIF/MET) for Seniors and Persons with Disabilities (SPD)	replaces guiding citation from APL 17-013 SPD to APL 22-024 PHM	X		
12	CMDM	CM-019	Private Duty Nursing Case Management For Members under the age of 21	As part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT), CM Services available via AAH or CCS for members under age of 21 receiving private duty nursing services	adds "Medi-Cal for Teens and Kids" language.	X		
13	CMDM	CM-028	Disease Management - Home Placed Developmentally Disabled HPDD Members	Role of RCEB liason and coordination with RCEB for HPDD Members (formerly Agnews)	Remove sections not applicable to population.	X		
14	CMDM	CM-030	Early Start	Process for AAH Case Management, along with PCPs, to refer children with development disabilites under the age of 36 months to RCEB's Early Start program				X
15	CMDM	CM-031	School Linked CHDP Services	Case management for pediatric members assigned to school based Primary Care Provider	Update "CHDP" part of P&P name and mention of "CHDP" within P&P to to "Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) (Medi-Cal for Kids & Teens)"	X		
16	CMDM	CM-032	Care Coordination - Local Education Agency Services	Duties of PCP, AAH, and school districts for member receiving serviced by Local Education Agencies (LEA)				X
17	CMDM	CM-034	Transitional Care Services	Structure of Plan's Transitional Care Services program				X

Policy Procedures Summary of Changes

18	CM	CM-035	Prescreening Process - ECM and CS Providers	Describes the prescreening and onboarding process for potential ECM and CS providers	Revised end-to-end process for prescreening potential ECM and CS providers: revised Entity Interest Form and Provider Certification Application, refined prescreening panel and provider scorecards, added timeframes for prescreening decisions, and specified a senior leadership approval process	X		X

POLICY AND PROCEDURE

Policy Number	HED-010
Policy Name	Doula Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal, Group Care
Effective Date	12/19/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/17/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

POLICY STATEMENT

Effective January 1, 2023, Alameda Alliance for Health (the Alliance) offers Doula Services as a preventive health benefit to pregnant members. These services may assist with a variety of concerns including but not limited to, the prevention of perinatal complications and improvement of health outcomes for birthing parents and infants. Doulas support the Alliance's Population Health Strategy. The Alliance doula benefit is guided by the Department of Health Care Services (DHCS) All Plan Letter 23-024 or superseding All Plan Letter or contract amendment.~~.~~

PROCEDURE

1. Recommendations for Doula Services

1.1. Alliance Doula Services require a written recommendation by a physician or other Licensed Practitioner of the healing arts within their scope of practice under state law.

1.1.1. The recommending practitioner ***does not*** need to be enrolled in Medi-Cal or be a Network Provider with the Plan.

1.1.2. The written recommendation should be kept in the member records maintained by doulas.

1.2. Recommendation for doula services includes the following authorizations:

1.2.1. One initial visit.

1.2.2. Up to eight additional visits that can be provided in any combination of prenatal and postpartum visits.
1.2.3. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage.
1.2.4. Up to two extended three-hour postpartum visits after the end of a pregnancy
1.3. The initial recommendation can be provided through the following methods:
1.3.1. Written recommendation in Member's record.
1.3.2. Standing recommendation for doula services by a physician group, or other group by a licensed Provider.
1.3.2.1. The standing recommendation issued by DHCS on November 1, 2023, fulfills this requirement until the time it is rescinded or modified.
1.3.3. Standard form signed by a physician or other licensed practitioner that a member can provide to the doula, such as the DHCS Medi-Cal Doula Services Recommendation form.
1.3.4. The Alliance may develop a recommendation form that best meets the needs for the Alliance and Alliance providers.
1.4. Additional visits:
1.4.1. A second recommendation is required for additional visits during the postpartum period.
1.4.2. A recommendation for additional visits during the postpartum period ~~CANNOT~~ cannot be established by standing order.
1.4.3. The additional recommendation authorizes nine or fewer additional postpartum visits.

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2. Role of Doula

2.1. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion.
2.2. Doulas provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of Members while adhering to evidence-based best practices.
2.3. Doulas are not licensed and do not require supervision.
2.4. Doulas offer various types of support, including health navigation; lactation support; development of a birth plan; and linkages to community-based resources.

3. Doula Qualifications

3.1. All doulas must (a) be at least 18 years old, (b) provide proof of an adult and infant Cardiopulmonary Resuscitation (i.e., CPR) certification from the American Red Cross or American Heart Association, and (c) they attest they have completed basic Health Insurance Portability and Accountability Act training.
3.2. Doulas must obtain training for their services through their choice of two pathways:
3.2.1. Training Pathway:
3.2.1.1. Certificate of completion for a minimum of 16 hours of training which includes the following topics:
3.2.1.1.1. Lactation support
3.2.1.1.2. Childbirth education
3.2.1.1.3. Foundations on anatomy of pregnancy and childbirth

3.2.1.1.4. Nonmedical comfort measures, prenatal support, and labor support techniques

3.2.1.1.5. Developing a community resource list

3.2.1.2. Attest that they have provided support at a minimum of three births

3.2.2. Experience Pathway: ***All requirements*** listed below need to be met for this option:

3.2.2.1. Attest that they have provided services in the capacity of a doula in either a paid or volunteer capacity for at least five years. The five years of experience in the capacity as a doula must have occurred within the last seven years.

3.2.2.2. Three written client testimonial letters or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization.

3.2.2.2.1. Letters must be written within the last seven years.

3.2.2.2.2. One letter must be from either a licensed Provider, a community-based organization, or an enrolled doula.

3.3. Continuing Education: Doulas complete three hours of continuing education in maternal, perinatal, and/or infant care every three years, maintaining evidence of completed training to be made available to the Alliance upon request.

3.4. Doulas are required to enroll as Medi-Cal providers consistent with APL 22-013 or any superseding APLs.

~~3.5. The Alliance will ensure required documentation by doulas for each visit within the member's medical record and be available for encounter data reporting. This documentation includes dates, time and duration of services provided to members. Documentation must also reflect information on the service provided and the length of time spent with the member that day.~~

~~3.6.~~3.5. "Enrolled doula" means a doula enrolled either through DHCS or through the Alliance.

~~3.6.1.~~3.5.1. Network Providers, including those who will operate as Providers of doula services, are required to enroll as Medi-Cal Providers, consistent with APL 22-013, or any superseding APLs, if there is a state-level enrollment pathway for them to do so.

4. Member Eligibility and Access

4.1. A member is eligible for Doula Services if they meet **ALL** the following criteria:

4.1.1. They are currently enrolled as an Alliance member.

4.1.1.1. Doulas must verify the Member's Alliance enrollment for the month of service.

4.1.1.2. Doulas must contact the Alliance or use the Alliance's provider portal to verify eligibility.

4.1.2. They receive a recommendation for doula services from licensed practitioner of the healing arts and would benefit from Doula Services or they request Doula Services.

~~4.1.2.~~4.1.2.1. The standing recommendation issued by DHCS on November 1, 2023, fulfills this requirement until the time it is rescinded or modified

4.1.3. They are either (a) Pregnant or (b) Pregnant within the past year.

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4.1.4. They can only receive Doula Services when provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy.

4.2. The Alliance as part of their network composition will ensure and monitor for sufficient doula services.

4.3. The Alliance will help doulas reduce any identified barriers to accessing hospitals/birthing centers when accompanying members for delivery regardless of outcome. If an Alliance member desires to have a doula during labor and delivery, the Alliance works with our in-network hospitals and birthing centers to allow the doula, in addition to the support person(s), to be present.

4.3.1. Alliance doulas may call Provider Services Call Center to request assistance with in-network hospital and birthing center access.

4.3.2. Members may call the Alliance Member Services Department for assistance with doula access.

5. Service and Billing Parameters

5.1. The Alliance provides doula services for prenatal, perinatal, and postpartum members.

5.2. Doula visits are limited to one per day, per member.

5.3. Services can be provided virtually or in-person with various locations including, but not limited to homes, office visits, hospitals or alternative birth centers.

5.4. A doula can bill for a prenatal or postpartum visit on the day of labor/delivery, stillbirth, abortion, or miscarriage support.

5.5. Extended three-hour postpartum visits provided after the end of pregnancy do not require the member to meet additional criteria or receive a separate recommendation.

5.6. The extended visits are limited to two visits per pregnancy per individual on separate days and are billed in 15-minute increments, up to three hours.

5.7. Doulas will work with the Member's Primary Care Provider (if information is available) or with the Alliance for coordination of care for any services available through Medi-Cal by referring the member to an Alliance provider to render the service. These services include but not limited to:

5.7.1. Behavioral health services

5.7.2. Belly binding after cesarean section by clinical personnel

5.7.3. Clinical case coordination

5.7.4. Health care services related to pregnancy, birth, and the postpartum period

5.7.5. Childbirth education group classes

5.7.6. Comprehensive health education including orientation, assessment, and planning (Comprehensive Perinatal Services Program services)

5.7.7. Hypnotherapy (non-specialty mental health service)

5.7.8. Lactation consulting, group classes, and supplies

5.7.9. Nutrition services (assessment, counseling, and development of care plan)

5.7.10. Transportation

5.7.11. Medically appropriate Community Supports services

5.8. Doula services ~~DO NOT~~do not include diagnosis of medical conditions, provision of medical advice or any type of clinical assessment, exam, or procedure. However, claims should include a diagnosis code provided by the referring provider.

5.9. Services that ~~ARE NOT~~are not covered under Medi-Cal or as doula services include:

5.9.1. Belly binding (traditional/ceremonial)

5.9.2. Birthing ceremonies (sealing, closing the bones etc.)
5.9.3. Group classes on babywearing
5.9.4. Massage (maternal or infant)
5.9.5. Photography
5.9.6. Placenta encapsulation
5.9.7. Shopping
5.9.8. Vaginal steams
5.9.9. Yoga

5.10. Doulas ~~ARE NOT~~are not prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit (i.e., a doula may help the postpartum person fold laundry while providing emotional support and offering advice on infant care).
5.10.1. The visit must be face-to-face, and the assistive or supportive service must be incidental to doula services provided during the prenatal or postpartum visit.
5.10.2. The Member cannot be billed for the assistive or supportive service.

5.11. Doulas ~~ARE NOT~~are not prohibited from teaching classes available at no cost to Members to whom they provide doula services.

5.12. Doula Documentation:
5.12.1. Doulas must document the dates, time, and duration of services provided to Members.
5.12.2. Documentation must also reflect information on the service provided and the length of time spent with the Member that day. For example, documentation might state, "Discussed childbirth education with the Member and discussed and developed a birth plan for one hour."
5.12.3. Documentation should be integrated into the Member's medical record and available for encounter data reporting.
5.12.4. The doula's National Provider Identifier (NPI) number should be included in the documentation.
5.12.5. Documentation must be accessible to the Alliance and DHCS upon request.

6. Reimbursement for Doula Services

6.1. The Alliance Claims Department makes payments in compliance with the clean claims requirements and timeframes outlined in the DHCS MCP Contract and Timely Payments under DHCS All Plan Letters. These requirements apply to both the Alliance and our Network Providers and Subcontractors. (See Alliance Policy *CLM-010 Family Planning and Sensitive Services)*.
6.2. MCPs must reimburse doulas in accordance with their Network Provider contract.
6.3. If a member chooses to see an out-of-network provider for abortion services, the reimbursement rate will not be lower, nor is required to be higher, than the Medi-Cal Fee-For-Service rate, unless the out-of-network provider and the Alliance mutually agree to a different reimbursement rate.
6.4. The Alliance is prohibited from establishing unreasonable or arbitrary barriers for accessing doula services.
6.5. Claims for doula services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.
6.6. Doulas ~~CANNOT~~ cannot double bill, as applicable, for doula services duplicative to services reimbursed through other benefits.

7. Population Health Management

7.1. In addition to recommending providers identifying a member's need for Doula services, the Alliance uses data driven approaches to determine and understand priority populations eligible for Doula services.

7.1.1. The Alliance uses available data sources and the Alliance risk tiering strategy to help identify members who meet the eligibility criteria for Doula services.

7.1.2. Priority populations are selected based on the unique needs of the Alliance membership, identified health disparities, and the DHCS Clinical Quality Strategy priorities.

7.1.3. The Alliance collaborates with community partners and providers to ensure priority populations connect to doula services.

7.1.4. The Alliance may also receive referrals from licensed practitioners for Doula benefits.

8. MCP Oversight

8.1. The Alliance must provide doulas with all necessary, initial, and ongoing training and resources regarding relevant Health Plan prenatal, perinatal, and postpartum services and processes, including any MCP services available to prenatal, perinatal, and postpartum members.

8.1.1. This training must be provided initially when doulas are enrolled with the MCPs, as well as on an ongoing basis.

8.2. The Alliance is required to provide technical support in the administration of doula services, ensuring accountability for all service requirements contained in the Contract, and any associated guidance issued by DHCS.

8.3. The Alliance ensures that Doula Services Providers have NPIs and that these NPIs are entered in the 274 Network Provider File.

8.4. The Alliance will ensure that all doulas complete three hours of continuing education in maternal, perinatal, and/or infant care every three years. Doulas must maintain evidence of completed training to be made available to DHCS upon request.

8.5. The Alliance must ensure doulas document the dates, time, and duration of services provided to Members.

8.6. The Alliance must ensure and monitor sufficient Provider Networks within their service areas, including doulas.

8.6.1. To support an adequate doula Network, the Alliance must make contracting available to both individual doulas and doula groups.

8.6.2. The Alliance works with Alliance network hospitals/birthing centers to help ensure there are no barriers to accessing doulas when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits regardless of outcome (stillbirth, abortion, miscarriage, live birth).

8.6.3. If an Alliance member desires to have a doula during labor and delivery, the Alliance will work with in-Network hospitals and birthing centers to allow the doula, in addition to the support person(s), to be present.

8.6.4. The Alliance coordinates out-of-Network access for doula services for members if an in-network doula provider is not available for medically necessary services. Out-of-Network care will be coordinated as is defined by Alliance policy *UM-002 Coordination of Care*.

8.7. The Alliance will monitor utilization of services and requirements and comply with all reporting and oversight requirements stipulated by DHCS.

8.7.1. Utilization monitoring will include, at the minimum, an annual review of claims and encounters for Doula services and grievances and appeals related to Doula services.
8.7.2. Based on monitoring of Doula services, the Alliance will ensure sufficient provider networks for Doula services.
8.7.3. The Alliance is responsible for ensuring Alliance Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.
8.7.3.1. These requirements are communicated by the Alliance to all applicable Subcontractors and Network Providers.

DEFINITIONS / ACRONYMS

The Alliance: Alameda Alliance for Health
DHCS: Department of Health Care Services
Licensed Practitioner: For the purposes of the doula benefit, a licensed practitioner includes physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.
MCP: Managed Care Plan
Network: Primary Care Providers (PCPs), Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom the Alliance enters into a Network Provider Agreement.
OON: Out-of-Network
Recommending Provider: The Licensed Practitioner who recommends a member for Doula services, and ensures the member meets medical necessity for Doula services.

AFFECTED DEPARTMENTS/PARTIES

Population Health and Equity
Case Management
Behavioral Health
Claims
Credentialing
Provider Relations

RELATED POLICIES AND PROCEDURES

CRE-002 Credentialing and Re-Credentialing
CLM-010 Family Planning and Sensitive Services
PH-002 Basic Population Health Management
UM-002 Coordination of Care

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alliance Population Health Strategy

REVISION HISTORY

New Policy: 12/19/2023
Revised: 6/12/2024; TBD

REFERENCES

APL 23-024 Doula Services or superseding All Plan Letters
APL 22-013 Interoperability and Patient Access Final Rule or superseding All Plan Letters

MONITORING

This policy will be reviewed annually to ensure effectiveness.

POLICY AND PROCEDURE

Policy Number	QI-115
Policy Name	Access and Availability Committee
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS, MCARE/DSNP
Effective Date	4/13/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	3/6/2024
Administrative Oversight Committee Approval Date	6/12/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") ensures its provider network is sufficient to provide accessibility, availability, and continuity of covered services as required by the regulatory and contractual requirements of the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), Title 28, CCR, Section 1300.67.2, Centers for Medicare and Medicaid Services (CMS), Title 42, CFR 422.112 and the National Committee for Quality Assurance (NCQA). The Access and Availability (A&A) Committee provides oversight to ensure: 1) timely access to and availability of quality health care services for all members within the Alliance and delegate network, and 2) the continuous monitoring of access to and availability of behavioral and medical health care services in adherence with regulatory and contractual access and availability requirements. The Access and Availability (A&A) Committee addresses barriers to care, including social determinants of health (SDOH) and provider shortages as well as implementing interventions to improve access, reduce disparities, and ensure equitable healthcare.

The A&A committee functions as a subcommittee of the Quality Improvement Health Equity (QIHE) ~~Program and reports findings to the Quality Improvement Committee (QIC).~~

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Scope

This policy applies to:

- Members enrolled in Alameda Alliance for Care MediCal, Group Care or Alameda Alliance Wellness.
- Network providers, including PCPs, specialists, and behavioral health providers
- Plan administrators, case managers, utilization managers and provider relations teams
- Delegated entities, vendors, and subcontractors

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PROCEDURE

The A&A Committee reviews the Alliance's access and availability activity data to evaluate whether the Alliance is meeting timely access to care and provider availability regulatory requirements. These regulatory requirements include provider network adequacy, appointment wait time, and geographical accessibility. The Committee identifies opportunities for improvement and provides recommendations to maintain and/or improve compliance with access and availability regulatory requirements.

A. Committee Membership

The Committee is comprised of members from all departments involved with member access to care and provider availability of health care services within the Alliance and delegate network. The Alliance's Medical Director oversees~~chairs~~ the committee with support from the Senior Director of Quality. The Alliance departments are responsible for providing the Committee with access and availability information, data, and reports generated as part of department operations. Information, data, and reports are shared and discussed with the Committee members and help to inform follow-up actions, corrective action plans (CAPs), and/or opportunities for improvement related to accessing timely health care services within the Alliance and delegate network. These findings inform the annual QIHE Program Evaluation annually. The roles of the departments involved in the Committee are as follows:

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i. Provider Services – monitors and provides data and information to the Committee related to activities that maintain the adequacy and integrity of the provider network.

ii. Member Services – manages member/provider reassignment changes and member complaint resolutions in one (1) business day. Member complaints and grievances related to access to and availability of health care services are reported to the Committee.

iii. Quality Improvement – monitors the quality of care provided by the Alliance provider network and reports activities to the Committee that pertain to access- related member and provider surveys, as well as facility site reviews (FSRs) and medical record reviews (MRRs) performed at primary care provider (PCP) sites.

iv. Grievance and Appeals – manages member grievances and appeals related to access to care, and reports to the Committee trends within the Alliance and delegate network.

v. Compliance – monitors and provides the Committee with ongoing updates related to timely access and availability regulatory requirements.

vi. Utilization Management – manages authorizations for medically necessary services and reports to the Committee trends in under- and over-utilization and out-of-network services.

vii. Healthcare Analytics – provides to the Committee health care services analytic support and survey data.

viii. Peer Review & Credentialing – monitors providers for practice regulatory compliance and reports on an ad-hoc basis to the Committee.

ix. Quality Assurance – monitors and provides the Committee with ongoing updates related to health plan accreditation.

x. Population Health and Equity~~Education~~ – monitors and reviews reports related to the provision of cultural and linguistic services, and provides the Committee with ongoing updates related to access to and availability of quality health care services.

B. Committee Monitoring Activities The A&A Committee reviews the Alliance's access and availability information, data, and reports on an ongoing basis to identify network adequacy and address any areas of non-compliance or deficiency related to member access to care and provider availability. If non-compliance or deficiencies are identified through the monitoring process, prompt investigation and corrective action is implemented to rectify identified deficiencies The Alliance Policy QI-114, Monitoring of Access and Availability Standards, describes the monitoring activities and reports that are provided to the Committee for review and improvement recommendations. The areas of monitoring the Committee oversees, to ensure compliance with network access and availability, include but are not limited to:

- Provider network capacity levels
- Facility Site Reviews
- Geographic accessibility
- Appointment availability surveys
- High-volume and high-impact specialists
- Access-related grievances and appeals
- Access-related potential quality issues
- Provider language capacity
- Wait time and telephone practices related to access
- Member and provider satisfaction surveys
- After-hours care

C. Committee Structure The A&A Chair is the Alliance's Access to Care Manager or designee. The Chair or designee is responsible for facilitating the Committee meetings and ensuring minutes are documented and reviewed with the Committee. The Committee meets on a quarterly basis, and ad-hoc in between meetings if needed.

Minutes of the Committee proceedings are prepared and maintained in the records of the Alliance's Quality Improvement Department. Agenda and meeting materials, including minutes of the previous meeting, are prepared and submitted to Committee members prior to the next meeting. The Committee meeting minutes are reviewed for approval by the Committee members.

D. Governance

The A&A Committee reports all activities to the Quality Improvement Health Equity Committee (QIHEC) on a quarterly basis. QIHEC is the appropriate body that approves the Committee's activities and provides recommendations to the Alliance on improving the access to and availability of quality health care services within the network.

MONITORING

The Alliance's A&A Committee monitors access to and availability of quality health care services within the Alliance's network. The A&A Committee reports to the Quality Improvement Health Equity Committee (QIHEC) annually for review and feedback. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.

DEFINITIONS / ACRONYMS

Corrective Action Plan - A standardized, joint response document designed to assist the provider in meeting applicable local, state, federal and Alliance requirements for a PCP site participating in Medi-Cal managed care.

High-Impact Provider – A provider who treat conditions that have high mortality and morbidity rates, as defined by NCQA.

High-Volume Provider – A PCP, a specialist, a provider of ancillary services, or a Community-Based Adult Services (CBAS) provider who has provided a minimum of 500 outpatient visits to 200 unique members, based on total encounters/claims within the year. (Note: This excludes encounter/claims data from ~~Kaiser, Beacon,~~ CHME, ModivCare , and PerformRx.)

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

PRV-003 Provider Network Capacity Standards
QI-104 Potential Quality Issues
QI-105 Primary Care Provider Site Reviews
QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-114 Monitoring of Access and Availability Standards
QI-116 Provider Appointment Availability Survey
QI-117 Member Satisfaction Survey
QI-118 Provider Satisfaction Survey
QI-124 Initial Health Assessment (IHA)/Health Information Form/Member Evaluation Tool (HIF/MET)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

A&A Committee Charter

REVISION HISTORY

4/13/2015, 3/24/2016, 5/19/2016, 3/9/2017, 3/1/2018, 11/16/2018, 1/17/2019, 3/19/2020, 5/20/2021, 6/28/2022, 03/21/2023, 6/12/2024

REFERENCES

DHCS Contract Exhibit A, Attachment 9, Access and Availability
Title 28, CCR, Section 1300.67.2, Accessibility of Services
DMHC Provider Appointment Availability Survey Methodology Measurement Year 2019 NCQA 2020 Standards and Guidelines for the Accreditation of Health Plans, Net 1 and 2: Accessibility of Services
CMS Medicare Managed Care Manual, Chapter 5 (Access to Services)

~~MONITORING~~

~~The Alliance's A&A Committee monitors access to and availability of quality health care services within the Alliance's network. The A&A Committee reports to the Quality~~

~~Improvement Health Equity Committee (QIHEC) annually for review and feedback. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.~~

POLICY AND PROCEDURE

Policy Number	QI-117
Policy Name	Member Satisfaction Survey (CAHPS)
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS, MCARE (DSNP)
Effective Date	12/18/2014
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	3/6/2024
Administrative Oversight Committee Approval Date	6/12/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance"), in conjunction with its survey vendor, Press Ganey (PG), conducts an annual Member Satisfaction Survey in accordance with Consumer Assessment of Healthcare Providers and Systems 5.1H (CAHPS) survey methodology, and that complies with the California Department of Health Care Services (DHCS) APL 17-014, with the DHCS Contract, Exhibit A, Attachment 5, Section 1.G., and with Centers for Medicare and Medicaid Services (CMS) Title 42, Code of Federal Regulations (CFR), Section 423.156.
The purpose of this policy is to outline the process for administering the Consumer Assessment of HealthCare Providers and Systems (CAHPS) Survey for members in enrolled in The Alliance MediCal plan or Alameda Alliance Wellness plan.

The CAHPS survey is designed to solicit feedback and evaluate experience from Alliance members. about their experience~~–~~ with the Alliance including ~~but,~~but not limited to the following areas:

- Satisfaction with the health plan~~;~~
Satisfaction with their health care providers, (i.e., PCP, specialist, and health education)~~; and~~ and
~~e~~Effectiveness of care.

It is the policy of the Alliance to:

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1. Administer the CAHPS survey annually in accordance with CMS, DHCS, and NCQA requirements
2. Ensure unbiased, standardized data collection using CMS-approved vendors
3. Analyze and report results to Quality Improvement Health Equity Committee (QIHEC) and regulatory agencies
4. Implement quality improvement initiatives to address member satisfaction concerns and disparities in care.

The CAHPS survey measures key aspects of care, including access to care, provider communication, customer service, and health plan performance.

Scope

This policy applies to:

- Members enrolled in the Alliance MediCal plan, Group Care members and members enrolled in Alameda Alliance Wellness plan.
- CMS-approved survey vendors responsible for administering CAHPS.
- Quality Improvement, Provider Relations, Analytics, and Member Services Teams.
- Health Equity, Health Care Services and Population Health Staff involved in addressing disparities.

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PROCEDURE

A. Member Satisfaction Survey Methodology

~~1)~~ The Alliance contracts with a nationally CMS-certified survey vendor to conduct an annual Member Satisfaction Survey that measures member experience. ~~with the health plan.~~

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The standard CAHPS Health Plan 5.1H survey tool, developed by the National Committee for Quality Assurance (NCQA), consists of scaled core questions and demographic questions. The survey process consists of a mixed methodology (mail and telephone). ~~which includes four (4) waves of mail (two (2) questionnaires and two (2) reminder postcards) with at least three (3) follow-up telephone calls as necessary over a 75-90 day period as outlined below.~~

- ~~A pre-notification letter~~
- ~~An email or letter invitation to a web survey~~
- ~~A web survey reminder email~~
- ~~Up to two survey mailings to non-respondents to the web survey~~
- ~~Telephone follow-up to non-respondents to the web and mail surveys~~

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~~3)~~2) Member selection for CAHPS survey participation is determined by the survey vendor randomly selecting a statistically valid sample of Alliance members from the health plan's database of members meeting continuous enrollment criteria.

4)3) The survey questions cover a variety of Alliance operations including items about member experience within the following attributes/composites:

i. Getting needed care (timely access)
ii. Getting care quickly (timely access)
iii. How well doctors communicate
iv. Customer service
v. Coordination of care
vi. Providing needed information
vii. Ease of filling out forms
viii. Claims processing (for Group Care only)

B. Member Satisfaction Survey Analysis and Reports

1. Designated Alliance Quality Improvement (QI) Department staff report the progress and results of the Member Satisfaction Survey for review and recommendations to the Access and Availability (A&A) Committee and the ~~Internal~~ Quality Improvement Health Equity Committee (~~I~~QIHEC). The review and analysis includes:
    a Comparison of results against previous years' performance and national benchmarks.
    ~~1.~~b Identification of populations with disparities (e.g., racial/ethic groups, limited English proficiency, disability status).
2. The Member Satisfaction Survey findings, conclusions and recommendations are then reported to the Quality Improvement Health Equity Committee (QIHEC) for feedback and approval. The committee reviews and regulatory reports are submitted as follows:
    ~~2.~~a Reports are submitted to CMS, DHCS, and NCQA as required
3. The Member Satisfaction Survey findings, conclusions and recommendations are incorporated into the annual Quality Improvement Program Evaluation and the QI Program Work Plan for the upcoming year. The QI Program Evaluation is reported annually to CMS, DHCS, per the DHCS Contract, Exhibit A, Attachment 14, Reporting Requirements. Quality Improvement actions include:
    a Development of member experience improvement plans
        i Identification of key drivers of member dissatisfaction (e.g. long wait times, difficulty accessing specialists)
        ii Development of targeted interventions (e.g., provider training, improved customer service).
    ~~Health Equity Interventions~~
        iii ~~Address language barriers and cultural competency training for providers.~~
        ~~Enhance telehealth and transportation services for underserved populations.~~
        ~~Implement member education programs to improve engagement.~~
    ~~Provider and Member Engagement~~
        ~~Conduct provider training on CAHPS-related topics (e.g., improving communication).~~
        ~~Host member advisory meetings to gather qualitative feedback.~~
        ~~Implement real-time member satisfactions surveys for ongoing feedback.~~

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4. The Member Satisfaction Survey tool, methodology, and survey results are submitted annually to CMS, DHCS, per DHCS APL 17-014.
5. QI management continuously monitors, tracks, and analyzes access and availability rates, continuity of care, and utilization satisfaction indicators to detect incidents, trends, and patterns of dissatisfaction with specific providers to identify opportunities for improvement with:
   i. Systemic operations issues/problems
   ii. Complaint types and resolution; and/or
   iii. Member identified needs
   iv. Track improvement initiatives and assess effectiveness
   v. Adjust strategies based on subsequent CAHPS survey results.

6. Documentation and Compliance
   i. All CAHPS-related activities will be documented and maintained for regulatory review.
   ii. Survey results, analyses, and interventions will be included in the annual QIHEC Program Evaluation.
   iii. The health plan will submit required reports to CMS, DHCS, and NCQA.

~~Failure to meet CAHPS survey participation or improvement targets may result in:~~

- ~~Corrective action plans (CAPs) from CMS or DHCS~~
- ~~Member experience improvement initiatives mandated by regulators~~
- ~~Potential financial penalties or star rating impacts.~~

~~iii.~~

C. Member Satisfaction: Additional Feedback

1) Additionally, the Alliance will utilize its ~~Member Advisory Committee (MAC), acting as the~~ Community Advisory Committee (CAC) or other means~~,~~ as an additional avenue through which member feedback will be solicited around timely access standards.

Responsibilities

Health Plan Responsibilities

- Contract with a CMS-approved CAHPS survey vendor.
- Provide accurate member data files to the vendor.
- Ensure the survey is conducted per CMS, DHCS, and NCQA protocols.
- Work with vendor to improve response rate.
- Review survey results and reports.
- Develop and implement quality improvement interventions based on findings.
- Report survey findings to the QIHEC, state regulators (DHCS), and CMS as required.

2. CAHPS Survey Vendor Responsibilities

- Administer the CAHPS survey following CMS, DHCS and NCQA protocols.
- Ensure confidentiality and unbiased survey administration.
- Provide comprehensive data analysis and benchmarking.

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- Submit required reports to the health plan in a timely manner.

3. Quality Improvement Health Equity Committee (QIHEC) Responsibilities
   - Review CAHPS results and trends.
   - Identify opportunities for member experience improvements.
   - Oversee action plans and interventions.
   - Monitor progress and reassess strategies annually.

MONITORING

Any findings and recommendations are reported quarterly to the A&A Committee and to QIHEC. The committees review and evaluate, on at least a quarterly basis, the information available to the plan regarding accessibility, availability, and continuity of care. This information includes, but is not limited to, results from member and provider surveys, member grievances and appeals, and triage and screening services data. The committees may recommend corrective action plans be issued by QI Department staff and Alliance Provider Services Department. This policy is reviewed and updated annually to ensure it is effective and meets regents.

DEFINITIONS / ACRONYMS

PG-Press Ganey.

AFFECTED DEPARTMENTS / PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

CLS-002 Member Advisory Committee
QI-101 Quality Improvement Program

QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

CAHPS Health Plan 5.1 Survey Tool
QI Program Description

QI Program Evaluation
QI Work Plan

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REVISION HISTORY

12/18/2014, 3/31/2015, 3/24/2016, 3/9/2017, 3/1/2018, 3/21/2019, 3/19/2020, 5/21/2020, 6/28/2022, 03/21/2023, 6/12/2024

REFERENCES

DHCS Contract, Exhibit A, Attachment 5, QI System, Section 1.G., and Attachment 14, Reporting Requirements

Title 42, CFR, Section 423.156

Title 42, CFR, Section 422.1520000

DHCS All Plan Letter 17-014 Quality and Performance Improvement Requirements

Centers for Medicaid and Medicare (CMS)

NCQA Accreditation Standards for Member Experience

~~MONITORING~~

~~Any findings and recommendations are reported quarterly to the A&A Committee and to QIHEC. The committees review and evaluate, on at least a quarterly basis, the information available to the plan regarding accessibility, availability, and continuity of care. This information includes, but is not limited to, results from member and provider surveys, member grievances and appeals, and triage and screening services data. The committees may recommend corrective action plans be issued by QI Department staff and Alliance Provider Services Department. This policy is reviewed and updated annually to ensure it is effective and meets regents.~~

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

POLICY AND PROCEDURE

Policy Number	QI-118
Policy Name	Provider Satisfaction Survey
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS, MCARE/DSNP
Effective Date	12/18/2014
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	3/6/2024
Administrative Oversight Committee Approval Date	6/12/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance"), in conjunction with its survey vendor, Press Ganey (PG), conducts an annual Provider Satisfaction Survey in accordance with valid and statistically reliable survey methodology, and that complies with Title 28, California Code of Regulations (CCR) 1300.67.2.2(d)(2)(C), Title 42, CFR 422.202(b) as well as with the Department of Health Care Services (DHCS) Contract, Exhibit A, Attachment 14, Reporting Requirements. The survey is designed to solicit level of provider satisfaction with the health plan. The Alliance surveys contracted physicians, non-physician medical providers, as well as non-physician mental health providers. The Provider Satisfaction Survey provides the Alliance with provider feedback about their experience with the Alliance in:

- Ensuring members timely access to and availability of covered quality health care services that are appropriate for their patients' condition.
- Establishing and maintaining a provider network, policies and procedures, and quality assurance that ensure compliance with clinically appropriate standards.
- Maintaining efficient processes necessary for members to obtain covered services as appropriate (e.g., referral and prior authorization process).
- Maintaining a system to ensure rescheduling of patients is done appropriately for missed visits.
- Providing members/patients with appropriate interpreter services when needed for scheduled appointments at all points of contact.

PROCEDURE

A. Provider Satisfaction Survey Methodology

1) The Alliance contracts with a nationally certified survey vendor to conduct an annual provider satisfaction survey that measures provider experience with the health plan.
2) The standard provider survey tool, developed by the Alliance and the survey vendor, consists of Likert scale operations questions, demographic questions, and at least one open-ended question.
3) The survey process consists of a two-wave mail and internet survey intervention with telephone follow-up conducted over a 90-day period.
4) The survey vendor chooses a statistically valid and stratified sample of Alliance providers from the Alliance's provider database.
5) The following provider types are excluded from the survey:
    - Pathologists
    - Radiologists
    - Emergency Medicine Providers
    - Physical and Occupational Therapists
    - Hearing Aid Dispenser Providers
    - Applied Behavior Analysis (ABA) Providers
    - Board Certified Behavior Analyst (BCBA) Providers
    - Chiropractors
    - Registered Dieticians
    - Hospitalists
    - Medical Geneticists
    - Anesthesiologists
6) The survey questions cover a variety of Alliance operations including items about provider experience within the following attributes/composites:
    i. All other plans (comparative rating)
    ii. Finance
    iii. Utilization and Quality Management
    iv. Network/Coordination of Care
    v. Pharmacy
    vi. Call Center Service
    vii. Provider Relations
    viii. Overall Satisfaction
    ix. Timely Access to Services
    x. Interpreter Services - Providers are asked about their perception of the following:
        a. The coordination of appointments with an interpreter.
        b. The availability of an appropriate range of interpreters; and
        c. The training and competency of available interpreters.
7) The survey vendor provides the Alliance with a post-survey report that includes the following:
    i. Summary Rate: a sum of the proportion of respondents who selected the most positive response options for the questions within the attributes/composites.
    ii. Demographic profile of survey respondents: area of medicine, physicians in practice, years in practice, portion of managed care volume represented by the Alliance, survey respondent, and insurance participation.

iii. Benchmark comparisons: comparisons of the Alliance's Summary Rates to the Summary Rates of identified benchmarks, to trend results if applicable, to the Summary Rate percentiles of benchmark percentiles, from physician and office manager respondents, and from respondents in the Primary Care and Specialty areas of medicine;

iv. Segmentation analysis: a summary of rate scores organized across provider profile demographics.

v. Correlation analysis: display of the survey attributes which have the strongest relationship with overall provider satisfaction with the Alliance.

B. Provider Satisfaction Survey Analysis and Reports

1) Quality Improvement management report the progress and results of the Provider Satisfaction Survey to the Chief Operating Officer and Provider Services for review and recommendations to the
Access and Availability (A&A) Committee ~~and the Internal Quality Improvement Committee (IQIC)~~ for the development of integrated cross functional performance improvement action plans as warranted.

2) The Provider Satisfaction Survey findings, conclusions and recommendations are then reported to the Quality Improvement Health Equity Committee (QIHEC) for feedback and approval, in accordance with Title 42, Code of Federal Regulations (CFR), Section 422.202(b).

~~3)~~ The Provider Satisfaction Survey findings, conclusions and recommendations are incorporated into the annual Quality Improvement Health Equity (QIHE) Program Evaluation and the QIHE Program Work Plan for MediCal, Alliance Health Wellness, and Group Care for the upcoming year. The QIHE Program Evaluation is reported annually to CMS and DHCS, per the DHCS Contract, Exhibit A, Attachment III~~14~~, 2.2 ~~Reporting Requirements.~~

~~4)~~3) The Provider Satisfaction Survey tool, methodology, and survey results are submitted annually in the DMHC Timely Access Compliance Report, per Title 28, CCR, Section 1300.67.2.2(g)(2)(F).

~~5)~~4) Quality Improvement management continuously monitors, tracks, and analyzes access and availability rates, continuity of care, and utilization satisfaction indicators to detect incidents, trends, and patterns of dissatisfaction with provider services. Provider Services then analyzes the data, specifically to identify opportunities for improvement with:

i. Systemic operation issues/problems
ii. Complaint types and resolutions; and/or
iii. Member identified needs

MONITORING

Any findings and recommendations are reported quarterly to the A&A Committee and to the QIHEC. The Committees review and evaluate, on at least a quarterly basis, the information available to the plan regarding accessibility, availability, and continuity of care. This information includes, but is not limited to, results from member and provider surveys, member grievances and appeals, and triage and screening services data. The Committees may recommend corrective action plans be issued by QI staff and Provider Services. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.

DEFINITIONS / ACRONYMS

PG-Press Ganey.

AFFECTED DEPARTMENTS / PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Health Equity Program
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

QIHE Program Evaluation
QIHE Work Plan
QIHE Program Description
DMHC Timely Access Compliance Report
Provider Satisfaction Survey Tool

REVISION HISTORY

12/18/14, 3/31/15, 3/24/16, 3/9/17, 3/1/18, 3/21/19, 3/19/20, 5/20/21, 6/28/22, 11/15/2022, 03/21/2023, 6/12/2024

REFERENCES

DHCS Contract, Exhibit A, Attachment III, 2.2 ~~14~~, QIHE Transformation Program (TP)~~Reporting Requirements, Section 5~~
Title 42, CFR, Section 422.202(b)
Title 28, CCR, Section 1300.67.2.2(d)(2)(C)
Title 28, CCR, Section 1300.67.2.2(g)(2)(F)

~~MONITORING~~

~~Any findings and recommendations are reported quarterly to the A&A Committee and to the QIHEC. The Committees review and evaluate, on at least a quarterly basis, the information available to the plan regarding accessibility, availability, and continuity of care. This information includes, but is not limited to, results from member and provider surveys, member grievances and appeals, and triage and screening services data. The Committees may recommend corrective action plans be issued by QI staff and Provider Services. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.~~

POLICY AND PROCEDURE

Policy Number	UM-015
Policy Name	Emergency Services and Post-Stabilization Services
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Senior Director, Health Care Services
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance and its delegates are responsible for the coverage and payment of Emergency Services and post-stabilization care services regardless of whether or not the Provider that furnished the services is a Network Provider, Subcontractor, Downstream Subcontractor, or Out-of-Network (OON) Provider.

Emergency Services are defined as services that provide care for an Emergency Medical Condition – as defined in Health and Safety Code section 1371.4 and Welfare and Institutions Code (WIC) section 14454.

Post Stabilization Care is delivered when the member is stabilized, but the health care Provider believes that they require additional Medically Necessary Covered Services and may not be discharged safely.

PROCEDURE

1. The Alliance maintains processes to ensure providers are not required to obtain authorization prior to the provision of emergency services and care needed to stabilize a member's emergency medical/mental health condition.
2. Emergency services and care also includes any additional screening, evaluation, care and treatment necessary to determine the existence of and to relieve or eliminate a psychiatric emergency medical condition.
    a. There is no limit on what constitutes an emergency medical condition based on a list of diagnoses or symptoms.
    b. When a member needs emergency department services while out of the service area, member is directed to visit the nearest Emergency Room.
    c. No prior authorization is needed for emergency services.

d. The member is reminded to contact his/her primary care physician at his first opportunity, and to follow up with that PCP.

~~1.~~3. Emergency rooms are notified that no authorization is required to stabilize the Member's condition; any services required after the Member's condition is stabilized will require authorization including a hospital admission.

4. The Alliance follows the same procedures for post-stabilization care for BH as with medical care. ~~mental health proviVoluntary and involuntary admissions are covered based on the Member's benefit coverage.~~
   a. For MediCal inpatient psychiatric admissions, Alliance will triage, screen, and refer admissions related to SED/SMI conditions admissions to Alameda County Behavioral Health Services.
   For Group Care, inpatient psychiatric admissions are managed by Alliance BH staff. ~~or 24 hour triage line for assistance.~~
   b. The Alliance provides a Post Stabilization Care process for members and providers to obtain timely authorization for ongoing medically necessary care, for circumstances where the member has received emergency services and care is stabilized, but the treating provider believes that the member may not be discharged safely.

5. The Alliance maintains a process to approve or disapprove requests for necessary post-stabilization medical care within one half hour (30 minutes) of the request.
   a. If The Alliance fails to approve or disapprove a health care Provider's request for authorization to provide medically necessary post- stabilization care services within one half hour of the request, or the Alliance cannot be contacted, the Medically Necessary post-stabilization care services are deemed as authorized in alignment with Title 28 CCR section 1300.71.4

6. Notifications can be made to the Alliance UM Department for post-stabilization services from a contracted facility, an in-area, non-contracted facility, or an out-of-area non-contracted facility 24 hours per day, 7 days per week:

7. UM Clinical Staff who receive notification from the Emergency Department staff, facility or provider about a Member in need of post-stabilization medically necessary services will open Nurse On Call Logs and document the request to include:
   a. Date and Time of Call
   b. Member Demographics (Name, ID Number, DOB)
   c. Requesting Facility Information
   d. Name of the health care provider making the request and Contact information
   e. Request
   f. Name of the Alliance representative responding to the request

8. The Alliance UM Staff reviews the presented information and determines if post-stabilization services are medically appropriate.
   a. If medically appropriate, the UM Staff will document the reason in the UM Authorization and issue authorization service request as defined in UM Policy 057 Authorization Service Request.
   b. If the Alliance UM Staff disagree regarding the need for necessary medical care, the UM Staff will outreach to the Alliance Medical Director to discuss a potential denial of post-stabilization services.

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9. If the Alliance Medical Director also disagrees regarding the need for necessary medical care and denies post-stabilization services, following stabilization of the enrollee, the Alliance UM Staff will:
    a. Coordinate the transfer of stabilized Members in an emergency department to an appropriate Network provider, if necessary, as required under Health & Safety Code (H&S) section 1371. This would apply in situations where an alternative general acute care hospital or hospital with mental health care facilities under contract with the plan agree to accept the transfer of the patient.
    b. Contact the PCP to assume responsibility for the care of the patient by having medical and/or mental health care personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement

    c. Assist in coordination of the discharge from the emergency department including ensuring the ER follow up care is in place, authorizations noted, transportation needs addressed and follow up communication is made to the PCP/Provider Group.

    d. The treating Provider may continue with care of the Member until an MCP physician is reached or one of the following criteria is met:
        i. An MCP physician with privileges at the treating Provider's hospital assumes responsibility for the Member's care;
        ii. An MCP physician assumes responsibility for the Member's care through transfer;
        iii. The MCP and the treating Provider reach an agreement concerning the Member's care; or
        iv. The Member is discharged.

10. For providers seeking authorizations and assistance with discharge planning and transfers to step down facilities Alliance clinical staff are available after hours, weekends and holidays to assist with coordination and urgent authorization requests that allow for transfers and discharges to occur with minimal delay.
    a. The Alliance maintains documentation of all requests for authorization and responses to such requests.

11. Emergency Departments contracted with the Alliance will be notified of the procedure to:
    a. Report system and/or protocol failures to the plan and the process for ensuring corrective action by contacting the Alliance Provider Services Department.
    b. Refer Alliance members who present at the emergency department for after-hours care or for non-emergency medical or behavioral health services by instructing the member to follow up with their Alliance PCP/BH Care Practitioner, to Alliance CM or delegate Case Management (CM) for timely follow ups to Primary Care, Behavioral Health Services, and social services.
    c. Care coordination is provided for all post-ER or hospitalization needs through the Alliance Case and Disease Management program, and contact information for the PCPs or other providers is on the Alliance website: https://alamedaalliance.org/providers/case-and-disease-management. Behavioral Health care coordination is provided by the Behavioral Health department and contact information is on the Alliance website: https://alamedaalliance.org/providers/non-specialty- behavioral-health-care-services.
    d. Referral forms for Prior Authorization requests and Case Management referrals for coordination of care are on the Alliance website for use by PCPs or other providers:

https://alamedaalliance.org/providers/provider-forms. https://alamedaalliance.org/providers/non-specialty-behavioral-health- care-services.

12. On an annual basis, The Alliance provides non-contracting hospitals in California to which one of its members can be transferred, the necessary Plan contact information to contact the health Plan.
    a. The Alliance provides UM contact information to the Department of Managed Health Care for updating to the DMHC Website "24 Hour Contact Line". This site serves as the notification process for non-contracting facilities to obtain UM post-stabilization assistance.
    b. On an annual basis Alliance sends a letter to all non-contracted hospitals in California with information on how to contact Alliance for Post Stabilization care.

13. The Alliance ensures that providers are reimbursed for emergency services and care provided to enrollees, until the care results in stabilization of the enrollee and
    a. The Alliance shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical/mental health condition.
    b. The Alliance maintains processes to ensure that providers are reimbursed for emergency services and care provided to its enrollees in and out of service areas, until the care results in stabilization of the enrollee
    c. The Alliance may deny reimbursement to a provider if the Member is not eligible for services at the time the service was rendered.
    d. The Member was admitted to the same hospital and ER facility charges are included in the Hospital claim.
    e. The Alliance, or its contracting medical providers, reasonably determines that the emergency services and care were never performed
    f. The Member did not require emergency services and care, and the Member reasonably should have known that an emergency did not exist. As noted in DMHC APL 17-017, the standard articulated by the Knox-Keene Act (section 1371.4 and 1371.5) is subjective and takes into consideration whether the enrollee's belief was reasonable given the enrollee's age, personality, education, background, and other similar factors. Whether the enrollee believed they were experiencing a medical emergency may not always be evident from the medical record of the visit because the records may not capture the mindset of the patient when he/she presented at the emergency room.

14. Any member responsibility for charges from post-stabilization care services (based on plan benefits) is limited to an amount no greater than the Member's co-payment, co-insurance, or deductible.

15. For non-contracted emergency services, any Member responsibility for charges from post-stabilization care services (based on Plan benefits) is limited to an amount no greater than what the Alliance would charge that member if he or she had obtained the services through the Alliance.

16. Delegation Oversite: The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards including a process by which Facilities can notify of a post-stabilization admission 24/7 availability of medical staff to authorize medically necessary post stabilization care and coordinate

transfer of stabilized Members to an appropriate network provider, if necessary. Refer to CMP-019 – Delegation Oversight and CMP-020 Corrective Action Plan. For Members assigned to a delegated Provider Group, the UM Clinical Staff will inform the caller to outreach to the designated delegate after hours call number

a. When an emergency department contacts Alliance, and the member is assigned to a delegated network, the one-half hour notification is enforced and Alliance will contact the delegated network UM Department or PCP with the emergency room contact information.
b. Alliance will log the notification to ensure timely payment for services.

17. Covered Ambulance Services associated with Emergency Care Services are:
    a. 911 emergency response system is activated for a condition the member reasonably believed was emergent
    b. Transportation of Enrollees to the nearest 24-hour emergency facility with Plan Physician coverage.
    c. For Transportation of Members to alternative appropriate facility, the attending physician should identify the type of transportation most appropriate to manage the Member's condition

18. Member based on the identified needs.
    a. For denied post-stabilization care, the Alliance or its delegates are not obligated to pay for the continuation of such care from and after the time it provides such notice to the provider. The Alliance should take into consideration the care necessary to effect the enrollee's transfer or discharge so as not to have an adverse impact upon the efficacy of such care or the enrollee's medical condition.

DEFINITIONS

Authorized Representative – any employee or contractor of Alameda Alliance for Health who directs the members to seek services.

Emergency Medical Condition – as defined in 42CFR §438.210€, 10CCR§2699.6700(9), and Health and Safety Code §1371.5(b) is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay-person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any bodily organ or part.

Emergency Services –

1. As defined by Centers for Medicare and Medicaid (CMS), are health care services provided to evaluate and stabilize medical/behavioral health conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson with average knowledge of medicine and health to believe that failure to get immediate medical care could result in:
    a. Serious jeopardy to the health of an individual or, in the case of a pregnant woman, the health of the woman or unborn child;
    b. Serious impairment to bodily functions;

c. Serious dysfunction of any bodily organ or part, or
d. Serious disfigurement.

2. Are inpatient or outpatient services furnished by a provider that is qualified to furnish these services, and are needed to evaluate or stabilize an emergency medical condition.

Post Stabilization Care – covered, medically necessary, non-emergency services (related to an emergency condition) at an out-of-network general acute care hospital needed to ensure that the patient remains stabilized from the time that the treating hospital requests authorization until:

1. The patient is discharged;
2. A contracted physician arrives and assumes responsibility for the patient's care; or
3. The treating physician and the contracted physician agree to another arrangement.

Prudent Layperson – a person who is without medical training and who draws on his/her practical experience when making a decision regarding whether emergency medical treatment is needed.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

BH-001 Behavioral Health Services
CLM-003 Emergency Services Claims Processing
CMP-019 Delegation Oversight
CMP-020 Corrective Action Plan
CMP-024 Subcontracted Relationships and Delegation
UM- 016 Transportation
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/26/2009, 9/23/2011, 3/16/2012, 5/9/2012, 9/18/2012, 7/14/13, 3/19/2014, 4/8/2014, 9/2/2014, 01/10/2016, 12/15/2016, 5/3/2018, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 10/19/2023, **8/21/2024; 02/21/2025**

REFERENCES

1. 28 CCR §1300.67.2(c)
2. 42CFR §438.114(e)
3. Balanced Budget Act (BBA) §422.100, Federal Register 34986
4. DHCS APL 15-015 Physical Health Care Covered Services Provided for Members Who Are Admitted To Inpatient Psychiatric Facilities.
5. DHCS APL 19-008 Rate Changes for Emergency and Post Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnosis Related Group Payment

6. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation and Related Travel Expenses
7. DHCS APL 23-009 Authorizations for Post-Stabilization Care Services
8. DHCS Contract, Exhibit A, Attachment 7, Sec. 7, Attachment 9, Sec. 7 4.
9. DHCS Policy Letter 00-01 Medi-Cal Managed Care Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program
10. DMHC APL 17-017 Standard for Determining Emergency
11. Title 10, Section. 1300.71.4 and Title 22, Section 53855
12. Health and Safety Code §§ 1300.71.4, 1317.1(a)(2)(A); 1345(b); 1367(i); 1371.4(a) (b)
13. Medicare Manual Chapter 4, Section 10.2
14. Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020.

MONITORING

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

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

~~POLICY AND PROCEDURE~~

	~~UM 015~~
	~~Emergency Services and Post-Stabilization Services~~
	~~Health Care Services~~

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~~**POLICY STATEMENT**~~

1. Emergency health care services are available and accessible within the service area 24 hours a day, seven (7) days a week.
2. The Alliance (Alameda Alliance for Health, (The Alliance) maintains contracts with medical/mental health practitioners, programs, and Emergency Services facilities to provide services to enrollees that require urgent or emergent medical/mental health care, including the services of one or more Physicians and one or more nurses on duty at all times.

a. Services include medical/mental health crisis intervention and stabilization as well as psychiatric inpatient hospital services within the service area 24 hours a day, 7 days a week

3. The Alliance ensures ambulance service is available to transport Enrollees to the nearest 24 hour emergency facility with Plan Physician coverage.

4. The Alliance provides a process for members and providers to obtain timely authorization for medically necessary care, for circumstances where the member has received emergency services and care is stabilized, but the treating provider believes that the member may not be discharged safely.

a. The Alliance maintains a process to receive notification of emergency room evaluations and subsequent admissions, whether voluntary or involuntary, 24 hours a day, 7 days a week.
b. UM Staff is available 24 hours, 7 days a week for providers seeking authorizations for post ER stabilization care. Calls after hours are triaged by Alliance clinical staff. Staff is also available on the weekends and holidays during the daytime for assistance with discharge planning and transfers to step down facilities.

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5. The Alliance ensures providers are reimbursed for emergency services and care provided to enrollees, until the care results in stabilization of the enrollee.

a. A Physician is available 24 hours a day to authorize Medically Necessary post- stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

b. The Alliance maintains a process to approve or disapprove requests for necessary post-stabilization medical care within one half hour (30 minutes) of the request.

i. If The Alliance fails to approve or disapprove a health care Provider's request for authorization to provide medically necessary post- stabilization care services within one half hour of the request, the Medically Necessary post-stabilization care services are deemed as authorized.

c. The Alliance maintains documentation of all requests for authorization and responses to such requests for post-stabilization medically necessary care.

6. The Alliance maintains a 24/7 telephone line for behavioral health services. See policy BH-002 Behavioral Health Services.

7. If The Alliance and the provider disagree regarding the need for necessary medical care, following stabilization of the enrollee, The Alliance shall assume responsibility for the care of the patient either by having medical personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the Plan agree to accept the transfer of the patient.

a. The Alliance shall assume responsibility for the care of the patient by either of the following:

i. Having medical and/or mental health care personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement -- Or --

ii. Having another general acute care hospital or hospital with mental health care facilities under contract with the Plan agree to accept the transfer of the patient.

8. The Alliance ensures that providers are reimbursed for emergency services and care provided to enrollees, until the care results in stabilization of the enrollee and

a. The Alliance shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical/mental health condition.

b. The Alliance maintains processes to ensure that providers are reimbursed for emergency services and care

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provided to its enrollees in and out of service areas, until the care results in stabilization of the enrollee

c. The Alliance reimburses providers for emergency services and care provided to its enrollees until the care results in stabilization of the enrollee and does not require a prior authorization for that reimbursement.

d. The Alliance may deny reimbursement to a provider if:

i. The Member is not eligible for services at the time the service was rendered.

ii. The Member was admitted to the same hospital and ER facility charges are included in the Hospital claim.

iii. The Alliance, or its contracting medical providers, reasonably determines that the emergency services and care were never performed

iv. The Member did not require emergency services and care, and the Member reasonably should have known that an emergency did not exist. As noted in DMHC APL 17-017, the standard articulated by the Knox-Keene Act (section 1371.4 and 1371.5) is subjective and takes into consideration whether the enrollee's belief was reasonable given the enrollee's age, personality, education, background, and other similar factors. Whether the enrollee believed they were experiencing a medical emergency may not always be evident from the medical record of the visit because the records may not capture the mindset of the patient when he/she presented at the emergency room.

9. The Alliance maintains processes to ensure providers are not required to obtain authorization prior to the provision of emergency services and care needed to stabilize a member's emergency medical/mental health condition.

10. Emergency services and care also includes any additional screening, evaluation, care and treatment necessary to determine the existence of and to relieve or eliminate a psychiatric emergency medical condition. There is no limit on what constitutes an emergency medical condition based on a list of diagnoses or symptoms.

11. Any member responsibility for charges from post-stabilization care services (based on plan benefits) is limited to an amount no greater than the Member's co-payment, co-insurance, or deductible.

a. For non-contracted emergency services, any Member responsibility for charges from post-stabilization care services (based on Plan benefits) is limited to an amount no greater than what the Alliance would charge that member if he or she had obtained the services through the Alliance.

12. Emergency Departments contracted with the Alliance

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will be notified of the~~pcalr~~to:

a. Report system and/or protocol failures to the plan and the process for ensuring corrective action by contacting the Alliance Provider Services Department.

b. Refer Alliance members who present at the emergency department for after-hours care or for non-emergency medical or behavioral health services by instructing the member to follow up with their Alliance PCP/BH Care Practitioner, to Alliance CM or delegate Case Management (CM) for timely follow ups to Primary Care, Behavioral Health Services, and social services.

i. Care coordination is provided for all post-ER or hospitalization needs through the Alliance Case and Disease Management program, and contact information for the PCPs or other providers is on the Alliance website: https://alamedaalliance.org/providers/case-and-disease-management. Behavioral Health care coordination is provided by the Behavioral Health department and contact information is on the Alliance website: https://alamedaalliance.org/providers/non-specialty-behavioral-health-care-services

ii. Referral forms for Prior Authorization requests and Case Management referrals for coordination of care are on the Alliance website for use by PCPs or other providers:. https://alamedaalliance.org/providers/provider-forms. https://alamedaalliance.org/providers/non-specialty-behavioral-health-care-services.

13. On an annual basis, The Alliance provides non-contracting hospitals in California to which one of its members can be transferred, the necessary Plan contact information to contact the health Plan.

a. The Alliance provides UM contact information to the Department of Managed Health Care for updating to the DMHC Website "24 Hour Contact Line". This site serves as the notification process for non-contracting facilities to obtain UM post-stabilization assistance.

b. On an annual basis Alliance sends a letter to all non-contracted hospitals in California with information on how to contact Alliance for Post Stabilization care.

14. Delegation Oversight: The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 – Delegation Oversight and CMP-020 Corrective Action Plan.

PROCEDURE

1. Alliance contracts stipulate that a PCP will be available 24 hours a day, seven (7) days a week for

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urgent/emergent requests from assigned members or from Emergency Department personnel about the PCP's members to/for:

a. Coordinate the transfer of care of a member whose emergency condition is stabilized.

b. Authorize medically necessary post-stabilization services.

c. General communication with emergency room personnel.

d. Provide medical advice and supervision (triage services) to assigned members either directly or through coverage arrangements with another credentialed provider.

e. When Alliance and the treating provider cannot reach an agreement concerning the Member's care and an Alliance physician is not available for consultation, Alliance will give the treating provider the opportunity to consult with an Alliance physician and the treating Provider may continue with care of the member until an Alliance Physician is reached or one of the following criteria is met:

- An Alliance physician with privileges at the treating provider's hospital resumes member's care
- An Alliance physician assumes care via transfer
- Alliance and treating physician reach an agreement regarding care
- Member is discharged.

f. If Alliance cannot be contacted within one half hour (30 minutes) of the request the authorization will be deemed approved.

2. If the Provider Group or PCP receives notice from an emergency department or is contacted by a Member who received services in an emergency department, the Provider Group or PCP shall provide the follow-up care and refer to CM, behavioral health providers or social services.

3. When an emergency department contacts Alliance, and the member is assigned to a delegated network, the one-half hour notification is enforced and Alliance will contact the delegated network UM Department or PCP with the emergency room contact information.

a. Alliance will log the notification to ensure timely payment for services.

4. When Alliance is responsible for post-stabilization services, and a member needs emergency department services while out of the service area, he/she is directed to visit the nearest Emergency Room.

a. No prior authorization is needed for emergency services.

b. The member is reminded to contact his/her primary care physician at his first opportunity, and to follow up with that PCP.

c. Emergency rooms are notified that no authorization is required to stabilize the Member's condition; any services required after the Member's condition is stabilized will

require authorization including a hospital admission.

d. Psychiatric admissions are managed by the Behavioral Health department. When notifications are made to the Alliance UM Department, UM staff will coordinate with the applicable mental health provider. Voluntary and involuntary admissions are covered based on the Member's benefit coverage.

- For MediCal inpatient psychiatric admissions, Alliance will triage, screen, and refer admissions related to SED/SMI conditions admissions to Alameda County Behavioral Health Services.
- For Group Care, inpatient psychiatric admissions are managed by Alliance BH staff or 24 hour triage line for assistance.

5. Notifications made to the Alliance UM Department for post-stabilization services from a contracted facility, an in-area, non-contracted facility, or an out-of-area non-contracted facility:

a. When UM Clinical Staff receives a notice from the Emergency Department staff or provider of a Member in need of post-stabilization medically necessary services, UM Staff will open ER Post-stabilization Log, and document the request to include:

i. Date and Time of Call
ii. Member Demographics (Name, ID Number, DOB)
iii. Requesting Facility Information
iv. Caller Name and Contact Information
v. Name of the health care provider making the request and Contact information
vi. Request
vii. Name of the Alliance representative responding to the request

b. For Members assigned to a delegated Provider Group, the UM Clinical Staff will inform the following information should be gathered:

i. Working Diagnosis
ii. Vital Signs
iii. Chief Complaints and symptoms such as bleeding, chest pain, impaired neurological status
iv. How the member was brought into the ED such as ambulance, paramedics, police transport, or employer, parent, spouse, friend, or self transport.
v. Duration of the condition such as sudden onset or length of days or weeks.
vi. Treatment or services already provided such as suturing, injections, medications, IV fluids, oxygen.
vii. Procedures or tests already conducted such as chest tube insertion, x-rays, MRI, laboratory work.
viii. Actual or suggested type of discharge from the Emergency Department such as hospital admission, transfer

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to another facility, discharge home with instructions and follow-up by PCP/BH Provider.

6. If The Alliance UM Staff reviews the presented information and determines if post-stabilization services are medically appropriate.

a. If medically appropriate, the UM Staff will document the reason in the UM Authorization and issue authorization service request as defined in UM Policy 057 Authorization Service Request.

b. If the Alliance and the provider disagree regarding the need for necessary medical care and denies post-stabilization services, following stabilization of the enrollee, the Alliance UM Staff will transfer the Member as soon as possible. UM Staff will contact the PCP to assume responsibility for the care of the patient either by having medical personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the Plan agree to accept the transfer of the patient.

i. The Alliance or the PCP/Provider Group shall assume responsibility for the care of the patient by either of the following:

a) Having medical and/or mental health care personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement Or

b) Having another general acute care hospital or hospital with mental health care facilities under contract with the Plan agree to accept the transfer of the patient.

ii. When agreement is made to accept the admission, The Alliance UM/BH Staff or the delegated Provider Group will issue the authorization for the admission.

iii. When post-stabilization services are denied and the agreement is made to discharge the Member from the emergency department, the UM Staff are responsible for ensuring the ER follow up care is in place, authorizations noted, transportation needs addressed and follow up communication is made to the PCP/Provider Group.

iv. When post-stabilization services are denied and the agreement is met and transfer to an in-network hospital is made, the Alliance UM Staff is responsible for the coordination of all necessary services to safely transfer the Member based on the identified needs.

v. For denied post-stabilization care, the Alliance or its delegates are not obligated to pay for the continuation of such care from and after the time it provides such notice to the provider. The Alliance should take into consideration the care necessary to effect the enrollee's transfer or discharge so as not to have an adverse impact upon the efficacy of such care or the enrollee's medical condition.

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7. Ambulance services are to be covered when:
a. 911 emergency response system is activated for a condition the member reasonably believed was emergent.
b. Ambulance Services to transfer to appropriate facility, the attending physician should identify the type of transportation most appropriate to manage the Member's condition.
8. Delegate Networks are required to adhere to all Emergency Service requirements including 24/7 availability of medical staff to authorized medically necessary post stabilization care and coordinate transfer of stabilized Members to an appropriate network provider, if necessary.

DEFINITIONS
Authorized Representative – any employee or contractor of Alameda Alliance for Health who directs the members to seek services.

Emergency Medical Condition – as defined in 42CFR §438.210€, 10CCR§2699.6700(9), and Health and Safety Code §1371.5(b) is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any bodily organ or part.

Emergency Services –
4. As defined by Centers for Medicare and Medicaid (CMS), are health care services provided to evaluate and stabilize medical/behavioral health conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson with average knowledge of medicine and health to believe that failure to get immediate medical care could result in:
a. serious jeopardy to the health of an individual or, in the case of a pregnant woman, the health of the woman or unborn child;
b. serious impairment to bodily functions;
c. serious dysfunction of any bodily organ or part, or
d. serious disfigurement.

5. Are inpatient or outpatient services furnished by a provider that is qualified to furnish

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these services, and are needed to evaluate or stabilize an emergency medical condition.

Post Stabilization Care – covered, medically necessary, non-emergency services (related to an emergency condition) at an out-of-network general acute care hospital needed to ensure that the patient remains stabilized from the time that the treating hospital requests authorization until:

1. The patient is discharged;
2. A contracted physician arrives and assumes responsibility for the patient's care; or
3. The treating physician and the contracted physician agree to another arrangement.

Prudent Layperson – a person who is without medical training and who draws on his/her practical experience when making a decision regarding whether emergency medical treatment is needed.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

1. CLM-003 Emergency Services Claims Processing
2. UM-057 Authorization Service Request
3. UM-016 Transportation
4. CMP-019 Delegation Oversight
5. CMP-020 Corrective Action Plan
6. CMP-024 Subcontracted Relationships and Delegation
7. BH-002 Behavioral Health Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/26/2009, 9/23/2011, 3/16/2012, 5/9/2012, 9/18/2012, 7/14/13, 3/19/2014, 4/8/2014, 9/2/2014, 01/10/2016, 12/15/2016, 5/3/2018, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 10/19/2023, **8/21/2024**

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~~REFERENCES~~

~~1. Title 10, Section. 1300.71.4 and Title 22, Section 53855~~
~~2. DHCS Contract, Exhibit A, Attachment 7, Sec. 7, Attachment 9, Sec.7 4. 28 CCR §1300.67.2(e)~~
~~5. Medicare Manual Chapter 4, Section 10.2~~
~~6. Balanced Budget Act (BBA) §422.100, Federal Register 34986~~
~~7. Health and Safety Code §§ 1300.71.4, 1317.1(a)(2)(A); 1345(b); 1367(i); 1371.4(a) (b)~~
~~8. 42CFR §438.114(e)~~
~~9. DHCS APL 19-008 Rate Changes for Emergency and Post Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnosis Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020.~~
~~10. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation and Related Travel Expenses~~
~~11. DHCS APL 15-015 Physical Health Care Covered Services Provided for Members Who Are Admitted To Inpatient Psychiatric Facilities.~~
~~12. DHCS Policy Letter 00-01 Medi-Cal Managed Care Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program.~~
~~13. DHCS APL 23-009 Authorizations for Post-Stabilization Care Services~~
~~14. DMHC APL 17-017 Standard for Determining Emergency~~

~~MONITORING~~

~~The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.~~

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

POLICY AND PROCEDURE

Policy Number	~~UM-025~~
Policy Name	Guidelines for Obstetrical Services
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	~~Utilization Management~~ Director, Social Determinants of Health
Lines of Business	MCAL, IHSS
Effective Date	12/4/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/17/2024~~TBD
Administrative Oversight Committee Approval Date	~~7/17/2024~~TBD

Commented [LA1]: recommend transitioning policy to CM; request Compliance assign a CM P&P number

POLICY STATEMENT

General Guidelines

A. The Alliance covers and ensures the provision of all medically necessary services for members who are pregnant and postpartum. All providers of obstetrical (OB) services to Members are required to follow the most current editions and strictest guidance of the following:

1. Standards for Obstetric Services and Guidelines and Oral Health Care during Pregnancy and Through the Lifespan from the American College of Obstetricians and Gynecologists (ACOG).
2. Guidelines for Perinatal Care, The American Academy of Pediatrics
3. Guide to Clinical Preventive Services, Report of the U.S. Preventive Services Task Force.
4. Newborn Screening regulations as set forth in Title 17, California Code of Regulations, Section 6500 et seq.
5. Comprehensive Perinatal Services Program (CPSP) regulations as set forth in Title 22.
6. Maternity Care Clinical Recommendations & Guidelines, AAFP
~~6.~~7. Assembly Bill No. 1936 – Maternal Mental Health Screenings

B. In addition to medical OB services, all Members receive perinatal support services, including an initial comprehensive risk assessment, reassessments, interventions as determined by risk, and an Individualized Care Plan (ICP).

C. All Members may initiate perinatal services without prior authorization with any Alliance OB practitioner. Perinatal services include basic and low risk nutrition, health education, and psychosocial support services. Referrals for high-risk OB, dental anesthesia, nutrition, health education, and psychosocial services are processed through the regular authorization process.

Obstetrical Care by Certified Nurse Midwives and Certified Nurse Practitioners

A. Pregnant Members may receive perinatal care services from a Certified Nurse Midwife (CNM) and Certified Nurse Practitioners (CNP).

B. CNMs and CNPs must contract with the Alliance to care for Alliance Members.

C. Prenatal care initiation does not require prior authorization from a PCP.

D. Members have the right to obtain out-of-network CNM/CNP services if a CNM/CNP is not available in the Alliance network within the time and distance requirements.

PCP Role in Care of Pregnant Members

A. PCPs are responsible for assessing Member's health status, including potential pregnancy.

B. PCPs may provide prenatal care to pregnant Members within their scope of practice.

C. PCPs are responsible for referring pregnant Members for prenatal care to an obstetrical (OB) practitioner within the Alliance or referring Members for voluntary termination of the pregnancy if desired by the Member.

D. PCPs are responsible for coordination of care with the OB practitioner, if necessary.

E. Members may also self-refer for prenatal care and voluntary termination within the Alliance. Basic prenatal care or preventive services do not require pre-authorization.

F. Members of childbearing age are informed of the availability of comprehensive perinatal services and how to access such services as soon as pregnancy is determined.

G. Alliance provider credentialing standards are applied to all prenatal care providers.

Multi-Disciplinary Perinatal Services

A. All Members receive perinatal support services in addition to medical Obstetrical (OB) care. Support services are in the areas of nutrition, health education, dental and psychosocial issues, and are provided by a variety of multi-disciplinary staff as appropriate, including doula services.

B. The Alliance maintains a Memorandum of Understanding (MOU) with the Alameda County Public Health Department for Maternal and Child Health.

PROCEDURE

General Procedures

A. **Accessing Perinatal Services**:

1. Once the PCP, Case Management or any other practitioner has established that the Member is pregnant, the Member may initiate prenatal care from an Alliance OB. Members may receive assistance from the PCP or Alliance Member Services in scheduling an appointment.
2. The initial prenatal visit must be made within one week of the request. Urgent prenatal visits must be scheduled the same day. Prenatal care should be initiated within the first trimester whenever possible. The initial prenatal visit may not be delayed for authorization.
3. Members may access basic support services without prior authorization. Basic services include the initiation of prenatal care visits, initial comprehensive risk assessment, all subsequent risk assessments each trimester, and low risk interventions conducted in the OB practitioner's office. Referrals for high-risk OB conditions, health education, nutrition, dental anesthesia, or psychosocial services are processed through the standard authorization process.

B. Initial Comprehensive Assessment (ICA). The ICA must be completed and documented at the initial prenatal visit, ideally within 4 weeks of entry to prenatal care. Providers must use a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. They must maintain the results of this assessment as part of the member's obstetrical record, which includes the following:

1. Physical examination to evaluate the Member's current condition, including height, weight, blood pressure, breast exam, abdominal and pelvic exams, and external and internal genitalia evaluation, as appropriate.
2. Comprehensive health and obstetrical history with information on past and current pregnancies, Estimated Delivery Date (EDD), menstrual history, family planning methods used, detailed history of past pregnancies and outcomes, medication sensitivities and allergies, family health and social history.
3. Nutritional assessment, to include dietary evaluation and prenatal vitamin/mineral supplementation.
4. Psychosocial assessment, to include past and present social and mental health history, substance use/abuse, support systems/resources.
5. Health Education assessment of language and education needs; and
6. Laboratory tests to include:
    a. Hemoglobin/hematocrit
    b. Urinalysis and microscopic examination or culture
    c. Urine testing to detect asymptomatic bacteriuria
    d. Blood group and Rh type determination
    e. Rubella antibody titer measurement

f. Gonorrhea culture, VDRL/RPR and chlamydia
g. Antibody screen
h. Cervical cytology (Pap Smear)
i. Hepatitis B testing
j. TB screen as indicated by risk status
k. Toxicology screen as indicated by risk status

7. Assessment of diabetic risk factors necessitating glucose screening, and any risk factors that may affect treatment (e.g., other medical conditions, significant past medical history, etc.).
8. HIV testing and counseling.

C. Individualized Care Plan (ICP). The initial prenatal evaluation must also include the development of an ICP, and interventions as appropriate. Each identified risk must be followed up with appropriate interventions consistent with ACOG standards and CPSP standards that are documented in the medical record. The interventions must be designed to ameliorate or remedy the specified risk condition and for Medi-Cal members, must be consistent with the requirements of Title 22, CCR, Sections 51348 and 51348.1. Each Member's ICP must document the Member's risk condition(s) and include the following elements:

a. Identification of proposed interventions
b. Identification of method(s) of intervention (e.g., referral, counseling by a specifiedstaff person)
c. Anticipated outcome of intervention
d. Identification of staff person responsible
e. Members should receive care through a multi-disciplinary team approach, with interventions by various staff types as needed.

D. The risk assessment may be completed virtually through a telehealth visit with the member's consent. Whether the assessment is performed in person, telephonically, or by telehealth, it will be conducted in a manner that promotes full sharing of information in an engaging environment of trust and in a culturally and linguistically appropriate manner.

Subsequent Comprehensive Prenatal trimester re-assessments: Comprehensive prenatal re-assessments for risk factors must be completed once each trimester after the initial prenatal visit and at the postpartum visit, using a comprehensive risk assessment tool that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348, and include documentation of obstetric/medical, nutrition, psychosocial and health education re-assessments.

E. The OB practitioner assesses risk factors and the need to access appropriate specialists to assist in the provision of care, including perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives, Licensed Midwives, Certified Nurse Practitioners, Doulas, and genetic screening. Alliance OB practitioners are responsible for the provision of counseling for nutrition, health education and psychosocial needs, or appropriate referrals to specialists and other services, as required.

F. If administration of the risk assessment tool is missed at the appropriate timeframes, the provider and the Alliance must ensure case management and care coordination are working directly with the member to accomplish the assessment.

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G. Each Member's ICP must be reviewed in the second and third trimesters, and in the postpartum period. The ICP should be reviewed more often as the Member's risk status is required and updated accordingly.

H. All Members must receive a prescription for prenatal vitamins as a standard of care.

I. Ante partum Care

1. Visits for an uncomplicated pregnancy include an exam every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of gestation, and weekly thereafter. Women with active medical or OB problems should be seen more frequently at intervals determined by the nature and severity of the problems.
2. Each ante partum visit must include the following:
   a. Measurement of blood pressure
   b. Weight
   c. Measured fundal height
   d. Fetal heart rate
   e. Urinalysis for albumin and glucose
3. The Alliance offers tests and screens recommended by ACOG at the appropriate times during the pregnancy, or as required.

J. Realizing that the pregnant Member has a variety of needs, Alliance allows perinatal services to be provided to Members by a variety of staff, within their scope of practice, as appropriate. Physicians, non-physician practitioners, nurses, medical assistants, social workers, dieticians, health educators, doulas or others may provide interventions as suitable.

K. Antenatal screening must be done when indicated to identify risks prior to pregnancy. Couples who have increased risks for producing abnormal offspring are offered the opportunity to undergo prenatal diagnostic studies after appropriate counseling.

L. OB practitioners are responsible for all education and specialized diagnostic referrals for their members. OB practitioners are responsible for the care and monitoring of pregnancy for Members, and coordination of all referrals and communication between specialists and PCPs.

1. Genetic Screening:
   a. Each pregnant Member receives screening and assessment for genetic risk factors. Members assessed as at risk for genetic disorders receive counseling and referrals, as appropriate.
   b. The initial prenatal evaluation must include a risk assessment and screening for genetic risk factors. Included in the assessment is a maternal serum alpha- fetoprotein (MSAFP) screen between 16-18 weeks of

gestation.

c. Factors which place Members at risk include:
    - Advanced maternal age (mother 35 years or older at expected time of delivery)
    - Previous offspring with a chromosomal aberration
    - Chromosomal abnormality in either parent
    - Family history of a sex-linked condition
    - Ancestry indicating risk for Tay-Sachs, sickle cell anemia, or other hemoglobinopathies

d. Newborns must also be screened and referred for genetic disorder evaluation as appropriate.

~~M.~~

~~N.~~M. As the primary practitioner of care during pregnancy, the OB practitioner is responsible for identifying the newborn's Physician on the ante partum record. In addition, the OB practitioner, with the hospital, coordinates referral of the newborn to an Alliance PCP for inpatient newborn care and continuing outpatient care.

~~O.~~N. The OB practitioner is responsible for coordinating the care of the Member back to the PCP after the postpartum evaluation is completed.

~~P.~~O. Dental screening is included as a part of routine prenatal care and is also available through the PCP. The PCP is responsible for screening Members for dental and oral health and making referral for treatment as appropriate. Referral for dental care does not require prior authorization by the Alliance, and Members may self refers to Medi-Cal dental practitioners. Healthy Families and Healthy Kids Members may access dental care through their contracted Dental Plan. See Policy UM-024 "Coordination of Care – Dental Services".

P. Maternal Mental Health Screening – Assembly Bill No. 1936 requires at least one maternal mental health screening during pregnancy, at least one additional screening during the first 6 weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate in the judgement of the treating provider.

Q. Pregnant Members may receive perinatal care services from a Certified Nurse Midwife (CNM) and Certified Nurse Practitioner, (CNP). CNMs/CNPs must meet Alliance's credentialing standards and be contracted with the Alliance. Services are limited to the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period. CNMs/CNPs must have physician back-up with an Alliance obstetrical practitioner who is contracted and credentialed by the Alliance and must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has privileges.

R. High Risk Obstetrical Care:

1. High risk OB Members must be referred for evaluation and care if beyond the scope of practice of the initial prenatal practitioner. High risk indicators (or markers) include:

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a. Evidence or history of asthma, gestational diabetes, pre-eclampsia, or eclampsia
b. Indication of multiple fetuses
c. Prior C-sections
d. History of complicated deliveries such as placenta previa or abruption placenta
e. History of pregnancy difficulties such as incompetent cervix
f. Prior premature labor and/or delivery
g. History of substance use/abuse
h. Homelessness
i. Under 18 or over 35 years of age.

2. The Alliance ensures that appropriate hospitals are available within the network to provide high-risk pregnancy services.

S. Intra-partum Care

1. As a part of their prenatal care and counseling, all Members must be informed of the hospital where they are going to deliver.

T. Postpartum Care must include the following services:

1. A comprehensive postpartum review and examination is required between three and eight weeks after delivery. The postpartum assessment must include the following 4 components:
   a. Obstetric/medical exam: an interval history and physical examination to evaluate the Member's current condition that includes weight, blood pressure, breast exam, abdominal exam, external and internal genitalia evaluation, and laboratory tests, as necessary;
   b. Nutritional assessment: dietary intake of mom and infant feeding status, that includes evaluation of problems/needs of the breastfeeding mother;
   c. Psychosocial assessment: evaluation of Member's emotional status, resources, and available support system; and
   d. Educational needs assessment.
2. The development of an ICP and interventions as appropriate.
3. Family Planning Evaluation: This evaluation includes education on family planning and counseling, referral, and provision of services.
4. Referral to a pediatric practitioner for follow-up, as indicated.
5. Referral to the WIC program for State Program Members or Members that meet WIC's financial eligibility requirements (see Section 12E, "Referrals to the Supplemental Food Program for Women, Infants, and Children (WIC)").
6. Immunization information, including rubella, if appropriate.
7. Evaluation for special problems and return-to-work status, as indicated.
8. Referral to a Dentist for preventative care (exam/ cleaning) or therapeutic (extractions, fillings, abscess drainage, root canal), and to promote oral health for infants.

a. Medi-Cal Postpartum Care Extension (PCE) under the Provisions of American Rescue Plan Act (ARPA)"

- i. "Effective 4/1/2022, the Medi-Cal postpartum coverage period was extended from 60 days to 12 months for all Medi-Cal eligible pregnant individuals under the providers of the ARPA. The 12 month postpartum coverage period for Medi-Cal eligible pregnant individuals begins on the last day of pregnancy and will end on the last day of the month in which the 365th day occurs. ARPA PCE is an automatic postpartum extension"
- ii. **"**Minor Consent beneficiaries do not qualify for ARPA PCE, as eligibility is month**-**to-month and cannot be applied automatically."
- iii. The only allowable reasons that an individual can be discontinued from the ARPA PCE protections during their pregnancy and/or the 365-day postpartum period are as follows:
  - Death
  - Loss of California residency
  - Beneficiaries request for discontinuance
  - Receipt of Supplemental Security Income
  - Aid on another Case

Certified Nurse Midwives/Certified Nurse Practitioners

A. Once pregnancy has been established by the PCP, Members may either request initiation of prenatal care from an Alliance Obstetrician, CNM/NPor other qualified prenatal care practitioner, or receive assistance from the PCP or the Alliance in scheduling an appointment.

B. Members may receive services from any gynecological or obstetrical specialist provider (OB/GYN), certified nurse midwife, certified nurse practitioner, or within the Alliance Network. Alliance providers are listed in the Provider Directory.

C. The law states Medi-Cal Members may get family planning services from any family planning agency, clinic, or provider who is willing to accept Medi-Cal rates.

D. CNMs must have physician back up with an Alliance network obstetrical practitioner credentialed by the Alliance for consultation, high-risk referral, and delivery services, as needed.

1. The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivery facility in which the CNM has delivery privileges.
2. The designated supervising physician or surgeon may not exceed the established ratio of 1:3 (full-time equivalent) CNMs.
3. The designated supervising or back-up physician is available in person or by electronic communication when the CNM is caring for patients.

E. The CNM must operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the CNM, and the administration within the Delegated Provider in which standardized procedures are used.

1. Standardized Procedures for the CNM define the scope of services provided by the CNM, and must identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures.
2. Standardized Procedures and Supervisory Guidelines must undergo periodic review, and are revised, updated, and signed by the supervising physician and CNM at each change in scope of services.
3. A current copy of the Standardized Procedures must be available at each facility where services are rendered for members.

Each CNM that prescribes controlled substances must have a valid DEA Registration Number.

PCPs

A. PCPs are responsible for assessing whether a member is pregnant, including providing pregnancy testing as appropriate.

B. Once a member is determined to be pregnant, PCPs are responsible for determining whether the Member plans to carry the pregnancy to delivery or wishes to pursue a voluntary termination.

C. If the Member plans to continue the pregnancy, the PCP is responsible for referring the Member to an OB, or giving the Member a choice of OB practitioners, within the Alliance network.

D. For Members wishing to pursue voluntary termination of the pregnancy, PCPs are responsible for assisting with the referral to an Alliance provider.

E. For pregnant Members in prenatal care, PCPs are responsible for coordinating care with the OB practitioner as necessary, including but not limited to:

1. Informing the OB by phone or in writing of any significant medical conditions that may impact, or be impacted, by the pregnancy.
2. Coordinating referrals with the OB for any necessary specialty care needed for the Member.

F. Providing updates to the OB during the pregnancy of changes in the Member's medical status as needed.

Multi-Disciplinary Perinatal Services

A. Members must have an Individualized Care Plan (ICP) developed that outlines a plan for addressing specific risks. These services are to be offered in the medical, health education, nutrition, and psychosocial areas. Participation in support services is voluntary, and Members have the right to refuse any or all the services offered.

B. Members may access basic perinatal support services from an obstetrical provider within the Alliance Provider Network, without prior authorization from the Alliance. Examples of basic perinatal support services include:

1. Basic nutritional counseling for women at low nutritional risk due to minor dietary deficiencies.
2. Basic health education interventions include counseling regarding exposure to secondhand smoke, counseling regarding alcohol use during pregnancy, etc.
3. A basic psychosocial intervention for women with low-risk conditions such as counseling women regarding sibling rivalry, and expectations for the pregnancy.

C. Basic perinatal support services are generally provided by one of the multi-disciplinary staff members in the perinatal practitioner's office. Examples of staff that can provide basic services include:
   1. MD or DO
   2. Nurse Practitioner
   3. Certified Nurse Midwife
   4. RN
   5. LVN
   6. Medical Assistant
   7. Social Worker
   8. Health Educator
   9. Health Care Worker

D. The Alliance ensures that pregnant and postpartum members are referred to Doulas as required under W&I Code section 14132.24.

E. Multi-disciplinary staff members in a perinatal practitioner's office only provideservices within their scope of licensure and appropriate training.

F. Members needing perinatal support services for high-risk conditions identified through the risk assessment tool are referred for appropriate intervention utilizing the Providers referral authorization process. Examples of high-risk conditions are outlined in Policy 12D1, "Guidelines for Obstetric Services."

G. . Perinatal support services for Members with high-risk conditions are generally provided outside the perinatal practitioner's office by licensed professionals including:
   1. Registered Dietitian
   2. Health Educator with master's level degree
   3. MFCC or LCSW

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

~~None.~~

Maternal mental health: mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

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AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CMP-015 Minor Consent to Medical Care
HED-010 Doula Services
UM-024 Coordination of Care – Dental Services
UM-029 Sensitive Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 7/17/2024, 2/24/2025

REFERENCES

1. DHCS Contract Exhibit A, Attachment 10. Provision 7
2. Title 22, CCR, Sections 51240, 51241, 51348, 51348.1
3. California Business and Professional Code 2725
4. W&I Code section 14132.24
5. Title 17, California Code of Regulations, Section 6500 et seq.
6. DHCS MMCD Policy Letter 12-003, Obstetrical Care-Perinatal Services
7. American Rescue Plan Act of the 117th Congress 2021-2022 (ARPA) (Pub. Law 117-2)
~~7.~~8. Assembly Bill No. 1936

MONITORING

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

POLICY AND PROCEDURE

Policy Number	UM-053
Policy Name	Breastfeeding: Lactation Management Aids, Donor Human Breast Milk & Nutrition Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Line(s) of Business	MCAL, IHSS
Effective Date	08/24/2017
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	~~11/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~12/18/2024~~TBD

POLICY STATEMENT

Alameda Alliance for Health (The Alliance) is committed to breastfeeding promotion and supports for all Alliance members. Breastfeeding provides many benefits to both the nursing infant and mother, particularly in the postpartum care. Breastfeeding offers health, nutrition, immunological, developmental, economic, psychological, social, and environmental benefits. Per the Centers for Disease Control, breastfeeding or the use of the mother's milk through breast pumping, can protect the infant from developing asthma, obesity, type 1 diabetes, ear infections, gastrointestinal infections, sudden infant death syndrome (SIDS) and necrotizing enterocolitis for preterm infants.

The American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologist (ACOG) recommends exclusive breastfeeding for the baby's first 6 months. Continued breastfeeding is a personal choice and may be influenced by whether the mother and infant both want to continue. The most health benefits are seen when breastfeeding occurs for 2 years or more, while most infants are introduced to complementary foods starting at 6 months of age. To support optimal breastfeeding and resulting health benefits, the Alliance makes lactation management aids (i.e. breast pumps and related durable medical equipment) and other support services available to members. Medically necessary lactation equipment like breast bumps and supplies may be needed to support longevity and

exclusivity of breastfeeding as recommended by the AAP and ACOG.

Reasons for needing a **breast pump and related supplies** may include, but are not limited to, the following:

- A newborn remains in the hospital after the mother is discharged
- Difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.
- A mother develops or has a medical condition that requires treatment of her breast milk before infant feeding, or precludes her from direct nursing at the breast
- Infant illness or disability that interferes with feeding, that may include hospitalization that precludes direct nursing at the breast on a regular basis.
- Infant has a congenital or acquired condition that precludes effective direct nursing at the breast
- Multiple births
- Any maternal illness, disease or use of medication (i.e. chemotherapy agents, or other FDA black box warnings) that requires the breastfeeding mother to "pump and dump" to maintain her milk supply for a limited period of time in order to resume breastfeeding when it is safe to do so.
- Physical separation of the mother and baby, including the mother's return to work or school.

Pasteurized Donor Human Breast Milk (PDHM) coverage as of Jan 1, 2025~~3~~ is a benefit ~~and includes human breast milk processing, storage and distribution from a licensed and approved facility~~for all lines of business to cover the provision of medically necessary pasteurized donor human milk obtained from a tissue bank licensed pursuant to Chapter 4.1 (HSC) as a basic Health Care Service. ~~:~~

- San Jose • Address: Mother's Milk Bank 1887 Monterey Road, Suite 110 San Jose, CA 95112 • Phone: 408 998-4550 • Email: recipient.coordinator@mothersmilk.org • Website: https://mothersmilk.org/

- San Diego • Address: University of California Health Milk Bank 3636 Gateway Center Ave, Suite 102 San Diego, CA 92102 • Phone: 858 249-MILK (6455) • Email: ucmilkbank@health.ucsd.edu • Website: https://health.universityofcalifornia.edu/patient-care/milk-bank

PDHM Criteria:

- A mother is unable to breast feed due to medical conditions;
- The infant cannot tolerate formula or has medical contra-indications to using formulas, including elemental formulas;
- The infant is born at a very low birthweight (less than1500 g) and very premature (less than 32 weeks gestation);
- The infant has a gastrointestinal anomaly, a metabolic/digestive disorder, or is in recovery from an intestinal surgery when digestive needs require additional support;

- The infant is diagnosed with failure to thrive (not appropriately gaining weight/growing);
- The infant has formula intolerance with documented feeding difficulty or weight loss;
- The infant has been diagnosed with hypoglycemia (low blood sugar), congenital heart disease, pre or post organ transplant, or another serious health condition when the use of banked donor human milk is medically necessary and supports the treatment and recovery of the infant; or
- The mother's milk must be contraindicated, unavailable (due to medical or psychological condition), or available but lacking in quantity or quality to meet the infant's needs.

This coverage includes 3 ounces per unit, 35 ounces per day, and is only good for 30 days. Coverage may be up to 12 months of age if it is medically necessary and appropriate. ~~Please reference the DHCS Provider Manual, Part 2 – Durable Medical Equipment (DME): Other DME Equipment for further information.~~

Nutritional counseling services related to breast feeding may be rendered by a physician. Nutrition services that support breast feeding include, but are not limited to:

- Persistent discomfort to the woman while breastfeeding
- Infant weight gain concerns
- Milk extraction
- Suck dysfunctions of the infant

Please reference the DHCS Provider Manual, Part 2 – Pregnancy: Postpartum and Newborn Referral Services for further information.

PROCEDURE

1) The Alliance covers all Lactation Management Aids as described in the most updated version of the DHCS Provider Manual Durable Medical Equipment (DME): Other DME Equipment, Breastfeeding: Lactation Management Aids. This includes breast pumps (manual or electric) and breast pump supplies that can be rented or purchased.

2) Either a Provider in the Alliance Network or an Alliance-contracted International Board-Certified Lactation Consultant can request authorization and distribution of Lactation Management Aids.

~~2)~~3) Each type of breast pump is considered a separate type of equipment. Distribution of one type of pump will not preclude the distribution of another pump as long as the authorization request is made by the providers and/or consultants can justify the need for both items that are not duplicates.

~~3)~~4) Lactation management aids can be distributed under either the mother or the child. However, if the mother or child has already received the specified pump, a second

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pump of the same type will not be distributed to the dyad.

~~4)~~5) Members may request personal grade pumps (E0603) up to one month prior to the Expected Delivery Date (EDD), but pumps will not be delivered until after birth or if medically necessity is met for other breast-feeding children.

DEFINITIONS / ACRONYMS

- **ACOG** – American College of Obstetricians and Gynecologist
- **APP** - American Academy of Pediatrics
- **DME** – Durable Medical Equipment
- **Pasteurized Donor Human Breast Milk (PDHM)** – breast milk that has been collected from screen donors, heat treated and pooled to make it safe for babies to consume. Donors are screened for medical and lifestyle history, and for use of prescription and nonprescription drug and substances. The milk is pulled from multiple donors and heat treated to kill harmful bacteria and viruses. The milk is frozen and stored until it's ready for use.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Health Education
Quality Improvement
Claims

RELATED POLICIES AND PROCEDURES

CM-001 Complex Case Management Screening Enrollment and Assessment
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-034 Transitional Care Services
UM-008 Coordination of Care – California Children's Services
UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment ((EPSDT)
UM-025 Guidelines for Obstetric Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Breast Pump Authorization Form

REVISION HISTORY

05/20/2021, 05/21/2020, 06/28/2022, 09/19/2023, 09/25/2024, 03/13/2025

REFERENCES

Bright Futures/ AAP
DHCS Provider Manual: Pregnancy: Postpartum and Newborn Referral Services, and Obstetrics – Medi-Cal.
DHCS MMCD Policy Letter 98-10, Breastfeeding Promotion
DHCS Pasteurized Donor Human Milk Billable Codes with HCPCS codes T2101 and K1005 May 2023
HSC Chapter 4.1
Other DME Equipment, Breastfeeding: Lactation Management Aids, August 2021

MONITORING

The Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. This policy will be reviewed for approval by the Alliance's Quality Improvement Health Equity Committee (QIHEC) annually.

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Breast Pump Authorization Form

REVISION HISTORY

5/20/2021, 5/21/2020, 6/28/2022, 9/19/2023, 12/18/2024

REFERENCES

Bright Futures/ AAP
DHCS Provider Manual: Pregnancy: Postpartum and Newborn Referral Services, and Obstetrics – Medi-Cal.
DHCS MMCD Policy Letter 98-10, Breastfeeding Promotion
Other DME Equipment, Breastfeeding: Lactation Management Aids, August 2021

MONITORING

The Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. This policy will be reviewed for approval by the Alliance's Quality Improvement Health Equity Committee (QIHEC) annually.

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	CM-002
Policy Name	Complex Case Management Plan Development and Management
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Director of Social Determinants of Health
Line(s) of Business	All
Effective Date	6/1/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~4/19/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

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POLICY STATEMENT

The Alliance offers Complex Case Management (CCM) services to all identified members who are assessed as appropriate for needing these services. The Alliance CCM services help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner.

The Alliance assists members to obtain this level of functional capability through the use of a Care Plan. Care Plans should be individualized, utilize evidenced-based care plans, and establish measurable goals and outcomes. The Case Manager (CM) and/or Social Worker (SW) collaborates with the member and/or their representative and care providers to establish a realistic time frame to achieve the goals and outcomes set by the Care Plan.

Care Plans are a guide for care management activities and focus on member interventions to achieve specific care management health goals to resolve identified problems and issues. Care Plans are based on the problems recommended from the Assessment process and continued management of the member's plan of care.

The Care Plan, and all associated documentation and correspondence, is documented in the Alliance Clinical Information System.

The Alliance will:

1. Ensure that all Alliance members are selected, as appropriate, for Complex Case Management.
2. Develop an individualized Care Plan based on an analysis of the General Assessment and Specialty Assessments, as applicable, and in collaboration with

the member and/or their representative, and care providers using Person-Center Planning.

- Person-Centered Planning:
    - Upon enrollment, the Case Manager (CM) and/or Social Worker (SW) provides or ensures the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the member's continuing health care needs.
    - Person-Centered Planning includes identifying each member's preferences and choices regarding treatments and services, and abilities.
    - The CM and/or SW will ensure the participation of the member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatment and services.
        - Additional individuals may include (but not limited to), the member's parents, legal guardians, authorized representatives, caregivers or other authorized support persons.
    - The CM and/or SW will communicate to members' parents, family members, legal guardians, authorized representatives, caregivers, or other authorized support persons all care coordination provided to members, as appropriate.
    - The CM and/or SW will ensure that members receive all necessary information regarding treatment and services so that they can make an informed choice.

3. Coordinate the interventions specified in the Care Plan using evidence-based care plans.
4. Establish measurable goals and outcomes as part of the Care Plan. Establish time frames for review and perform follow up on the achievement of these goals and outcomes according to those established time frames.
5. Maintain procedures for documenting the CCM plan of care using a Clinical Information System.
6. Refer members to other services, as appropriate.

Complex Case Management Services are provided by the Alliance, in collaboration with the primary care provider and shall include, at a minimum:

1. Basic Population Health Management Services (See CM-004 Care Coordination of Services P&P for more details.)
2. Management of acute or chronic illness, including emotional and social support issues and social determinants of health needs by a multidisciplinary case management team
3. Intense coordination of resources to ensure member regains optimal health or improved functionality
4. With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually
5. For transplant members, additional collaboration will occur with the member's transplant center in order to best meet the individual needs of the member

~~The Alliance delegates Complex Case Management (CCM) for a small proportion of its population. The delegates are required to follow the National Committee for Quality Assurance (NCQA) standards. Routine reports are submitted to the Alliance regarding the delegates' performance and annually, at a minimum, a delegation audit is conducted.~~

Commented [AL1]: @lily -- can we please double check this? We don't currently delegate CCM to any of our delegates (was this a past reference to Kaiser?) If so, can we please remove language?

PROCEDURE

Scope:

This Policy and Procedure addresses the Care Plan Development and Care Plan Management steps of Complex Care Management (CCM). Refer to *CM-001, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment* for information on the initial steps of the CCM process. Utilization Management determinations are not included in the scope of the CCM program.

Care Plan Development

1. Case Manager and/or Social Worker develops a Care Plan for members who indicated willingness to participate in CCM from the Enrollment process. Care plan development entails the following:
    a. Development of case management goals, including prioritized goals
    b. Identification of barriers to meet the goals and complying with the plans
    c. Development of schedules for follow-up and communication with members
    d. Development and communication of member self-management plans
    e. Assessment of progress against CCM plans and goals, and modifications as needed
2. The CM and/or Social Worker, using the member's input, will assign a target goal date. Short term goals are defined as achievable within 30 days. Long term goals are achievable within 31 to 90 days. Goals should not be set greater than 90 days in order to facilitate re-assessment and review or resetting of member's goal. The goals will be prioritized based on the discussion with the member and/or caregiver and will be documented accordingly in the Clinical Information System. Goal priorities will be assigned on a scale from 1 (High) to 10 (Low). These priorities will be assigned based on potential impact on future hospitalizations, Emergency Department visits or quality of life. The member's preferences are taken into consideration in determining the priorities.
3. Within the Goal setting screens, an option exists to select barriers to achievement of the goal. The CM and/or SW should select barriers as appropriate to the case. The CM and/or SW should document issues of barriers were assessed, even if no barriers were identified.
4. Finally, interventions should be selected, created, and added. The goals and priorities of the goals are evaluated at the next scheduled call with the member.
5. Care Plan activities should be thoroughly documented within the Clinical Information System and additional notes added as necessary to ensure that the assessment and resultant Care Plan addresses each identified problem. There should be a minimum of 3 goals with corresponding problem(s) prioritized through

collaboration of the member and the CM/SW care team. One goal must be related to self-management.

6. When planning for transitions of care, the CM and/or SW will contact the place of transfer and follow-up with the member and/or caregiver within 1 business day of notification of transfer.

Collaboration and Communication with the Member and Provider

1. Once the Care Plan has been developed, the CM and/or SW shall schedule a time and create a Contact Member task to self, if not already done at the close of the Assessment, to review the plan with the member and obtain agreement on the goals and interventions. During the follow-up call, motivational interviewing techniques should be used to engage the client and obtain agreement on the Care Plan. Changes to the Care Plan should be made as appropriate documenting member's readiness to change and agreement with the Plan.
2. After the Care Plan is agreed upon with the member, a letter summarizing CCM services and the Care Plan (member's self-management plan) should be mailed to the member and/or caregiver.
3. With the member's permission, the provider of care (primary provider and/or specialist managing care) should be notified that the member is receiving care management services.
    a) A summary of draft Initial Care Plan is sent to the provider with a request to review and provide input into the final Care Plan.
    b) For updates to the Care Plan or the annual reassessments, the Providers are provided with the revised Care Plan to allow opportunities to provide input into the final Care Plan.

Care Plan Management

1. The Care Plan, its goals and interventions schedule for completion shall guide the CM and/or SW in managing the case. Additionally, the member shall be provided the name and number of the CM to contact as needed.
2. In managing the case, the CM and/or SW shall:
    a. Evaluate cultural, linguistic needs, preferences, or limitations in building the Care Plan and interacting with the member.
    b. Evaluate visual and hearing needs, preferences, or limitations in building the Care Plan and interacting with the member.
    c. Address the availability of caregiver resources and their involvement with the member.
    d. Address available benefits and any needs for community and financial resources.
    e. Provide the member with available programs, resources and program requirements based upon their and their caregiver's preferences and desired level of involvement in their plan of care.
    f. Supporting and assisting the member in accessing all needed services and resources, including across the physical and behavioral health delivery system.
        1. Make and follow up on referrals to resources. Follow up on all referrals will be scheduled at the time of the referral and can be

combined as part of the next monthly contact, if not considered urgent.

ii. Follow up will include ensuring members receive all medically necessary services including Community Supports.

g. Contact the member monthly, at a minimum, or more frequently based on the needs of the member and the referrals made. Each contact includes an assessment of the member's progress towards the goals, evaluation of the barriers to the goals and adjusting the care plan and its goals, as needed.

i. The CM and/or SW will facilitate and encourage the member's adherence to recommended interventions and treatment.

h. Conduct case staffing (Case Rounds) with members of the care team (Medical Director, Director of CM/DM, Behavioral Health clinicians, Health Coaches and others) to ensure that the best thinking and specialized expertise is available in care plan decisions.

i. Cases that remain open after 90 days require review at Case Rounds. Cases where the CM deems multi-disciplinary assistance is needed can be referred at any time to bi-weekly Case Rounds.

j. Coordinate with the providers of care about progress towards or lack thereof with the plan of care.

i. This includes documenting in the member's medical record all the member's services and treating providers.

k. Continually update and evaluate the Care Plan based on member need (to address unmet service needs) and using information from ongoing screenings and assessments. Promptly close the case per *CM-003, Complex Case Management Plan Evaluation and Closure*.

Additional CCM Care Plan Guidelines

1. All interactions with the member and/or providers of care concerning the Care Plan shall be documented in the Clinical Information System. In the event that a template or field entry is not available, Complex Note entries shall be used in the Clinical Information System.
2. In the absence of system generated recommendations of care the CM and/or SW will review applicable, evidenced-based guidelines published or referenced by the Alliance and/or from The National Guideline Clearinghouse (www.guideline.gov) and/or medical and behavioral healthcare specialty societies to determine the goals and interventions of the Care Plan. The Clinical Information System's recommendations are also based on professionally recognized standards of care, including industry standards and, where appropriate, based upon competent evidence-based practices such as the National Guideline Clearinghouse and other credible sources.
3. Care Plan development and monitoring time frame standards are as follows:
   a. Obtain consent to CCM services within 5 calendar days of completing all sections of the Assessment. If unable to contact member, Unable to Reach (UTR) protocols are ~~met~~followed.

b. Complete Care Plan within 60 calendar days of enrollment. Enrollment is defined as when the member consents to Complex Case Management and a Complex Case is opened in the Clinical Information System.

c. At least m~~M~~onthly contact from time of consent.

d. Referrals are made within 5 calendar days of identifying need.

e. Case closure within 90 days of Care Plan development unless otherwise extended at Case Rounds.

DEFINITIONS

Active Complex Case Management: A member is defined as in Active Complex Case Management at the time a General Assessment is completed and the member is entered into complex case management by the Case Manager and/or Social Worker.

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 that can be used to compile data. Alliance uses a General Assessment, Diabetes and Asthma Assessments and Health Risk Assessments for the SPD and ACC populations.

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.

Care Plan Barriers: Issues that could impede the progress in completing a care plan goal.

Care Plan Goal: Goals are specific aims to which the Care Plan is directed. Goals are measurable and are based on the assessment of the member's needs.

Care Plan Intervention: Interventions are strategies or actions taken to assist the member in achieving their goals.

Case Management (CM): A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. (Case Management Society of America).

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. (NCQA).

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.

AFFECTED DEPARTMENTS/PARTIES

Provider Relations
Utilization Management
Quality Oversight
Case and Disease Management
Alliance Members
Alliance Delegated Groups
Alliance Directly Contracted Providers

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Attachment 1. CM Member Welcome Letter
Attachment 2. Provider Notification of member enrollment in CCM

CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
CM-003 Complex Case Management Plan Evaluation and Closure
CM-004 Policy and Procedure, Care Coordination of Services

REVISION HISTORY

12/05/2012, 3/1/2016, 1/4/2018, 5/3/2018, 04/16/2019, 05/21/2020, 05/21/2021, 09/16/2021, 03/22/2022, 6/20/2023, 6/12/2024

REFERENCES

1. DHCS Two Plan Model Contract Exhibit A, Attachment 11 Case Management and Coordination of Care, Section B
2. NCQA QI 5: Complex Case Management
~~3. Clinical Information System User Guide v. 5.3~~

Commented [AL2]: is this referencing TruCare? if so, recommend removing the version number

MONITORING

The Chief Medical Officer, Sr. Director, Health Care Serivces, and Director, Social Determinants of Health ~~Case and Disease Management, and Chief Operations Officer~~ review:

1) Timeliness of follow on Referrals, Care Plan Development initiation and completion
2) Monthly member contact rates
3) Case Rounds
4) Care Plan audits using NCQA file review forms
5) Readmission and hospitalization rates of members in CCM
6) Satisfaction with CCM services

ATTACHMENT 1

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Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

Case and Disease Management Department
Phone Number: **1.510.747.4512**
Toll-Free: **1.877.251.9612**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

www.alamedaalliance.org

[Date]

[Member First Name] [Member Last Name] Member ID: [Member ID]
[Member Address]
[City], [State] [Zip Code]

Dear [Member First Name] [Member Last Name],

Thank you for choosing Alameda Alliance for Health (Alliance) for your healthcare needs. We are here to help you stay healthy and active. We are sending you this letter to invite you to join our Complex Case Management (CCM) Program. We designed this program to help you reach your health goals to the highest level of wellness and function possible.

The Alliance will follow up with you on [Follow-Up Date] to discuss your personalized *Care Plan*.

If you have any questions about our CCM program, you can find out more at **www.alamedaalliance.org** or call:

Alliance Case and Disease Management Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4512**
Toll-Free: **1.877.251.9612**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

The program is designed to help you:

- Better manage your health and take care of yourself.
- Find programs to meet your health care needs.
- Help you reach health goals.
- Understand your illness, and when and how to ask for help.

While you are in the CCM Program, we will have frequent phone calls. During the calls, we can discuss concerns you may have with your health and getting the services you need. What we discuss and any handouts mailed to you do not replace your doctor's advice or orders. We will send a letter to your doctor to inform them that you are part of the program. It is vital that you keep your appointments and inform your doctor about any changes in your health.

Enclosed is the Advance Health Care Directive form for you to fill out. This form lets your doctor, family, and friends know how you want to be treated if you get too sick to make medical decisions for yourself.

We suggest that you:

1) **Discuss** how you want to answer the questions on the form with your family, doctor, or others who are close to you.
2) **Complete** the parts of the form that are important to you.
3) **Share** the complete and signed form with your family and doctor.

This service is available for Alliance members at no cost. You do not have to join the program if you do not want to. Your health plan benefits, and coverage remain the same.

You may also leave the CCM Program at any time if you find that it is not right for you, without consequence. We are here to support you achieve your personal health goals.

If you have a problem with your health care services, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

Best of Health,
Health Care Services
Alameda Alliance for Health

Enclosed:

- Advance Health Care Directive Form
- Alliance Notice of Privacy Practices

~~ATTACHMENT 2~~

ATTACHMENT 2

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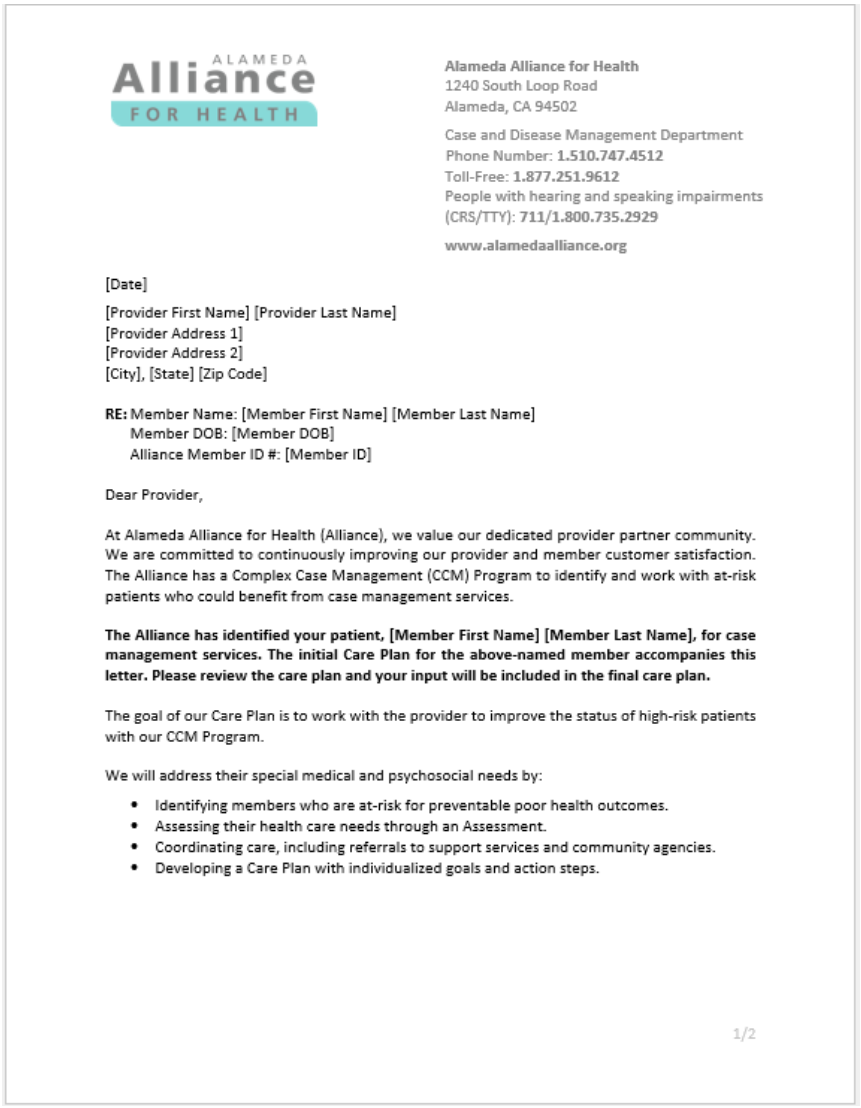

ALAMEDA Alliance FOR HEALTH

Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

Case and Disease Management Department
Phone Number: **1.510.747.4512**
Toll-Free: **1.877.251.9612**
People with hearing and speaking impairments
(CRS/TTY): **711/1.800.735.2929**

www.alamedaalliance.org

[Date]

[Provider First Name] [Provider Last Name]
[Provider Address 1]
[Provider Address 2]
[City], [State] [Zip Code]

RE: Member Name: [Member First Name] [Member Last Name]
Member DOB: [Member DOB]
Alliance Member ID #: [Member ID]

Dear Provider,

At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction. The Alliance has a Complex Case Management (CCM) Program to identify and work with at-risk patients who could benefit from case management services.

The Alliance has identified your patient, [Member First Name] [Member Last Name], for case management services. The initial Care Plan for the above-named member accompanies this letter. Please review the care plan and your input will be included in the final care plan.

The goal of our Care Plan is to work with the provider to improve the status of high-risk patients with our CCM Program.

We will address their special medical and psychosocial needs by:

- Identifying members who are at-risk for preventable poor health outcomes.
- Assessing their health care needs through an Assessment.
- Coordinating care, including referrals to support services and community agencies.
- Developing a Care Plan with individualized goals and action steps.

1/2

To include your additional input, concerns, or observations that you may have, please call or fax:

Alliance Case and Disease Management Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4512**
Toll-Free: **1.877.251.9612**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
Fax: **1.510.747.4130**

Please provide the member's full name, date of birth, and Alliance member ID number. Members may opt out of the CCM Program at any time by calling the toll-free number above.

If you or our members have a complaint about the program, please call or visit our website:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
www.alamedaalliance.org/providers/provider-resources/grievances-appeals

Thank you for your continued partnership and the high-quality care that you provide to our members. Together we are creating a healthier community for all.

Sincerely,
Health Care Services
Alameda Alliance for Health

Enclosed: Care Plan

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	CM-003
Policy Name	Complex Case Management Plan Evaluation and Closure
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	All
Effective Date	12/5/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~4/19/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

POLICY STATEMENT

The Alliance offers Complex Case Management (CCM) services to all identified members who are assessed as appropriate for needing these services. The Alliance CCM services help members regain optimum health or improved functional capability, in the right setting and in a cost- effective manner.

The Alliance will ensure that all CCM cases are closed in a timely manner using criteria for case closure. The Case Manager will ensure follow-up services are arranged prior to case closure.

The Alliance will maintain procedures for evaluating and documenting the decision to close the case using a Clinical Information System.

~~The Alliance delegates CCM for a small proportion of its population. The delegates are required to follow the NCQA standards. Routine reports are submitted to the Alliance regarding the delegates' performance and annually, at a minimum, a delegation audit is conducted.~~

Commented [AL1]: @lily - remove? (since we no longer delegate CCM?)

PROCEDURE

Scope

This Policy and Procedure addresses the Care Plan Evaluation and Closure steps of the Complex Care Management (CCM) process. This policy does not address overall CCM program evaluation, but rather evaluation of the individual case to determine whether to close the case to CCM and the arrangement, as necessary, of any follow up services the member may require.

Care Plan Closure Evaluation

1. The Case Management (CM) staff will close a case whenever the following criteria has been met:
    a. Goals met/Improved health status
    b. Interventions not successful/all resources exhausted
    c. Termination of coverage
    d. Unable to establish or maintain contact with a member
    e. No longer meets criteria other than eligibility requirements
    f. Member/caregiver declines services.
    g. Death of member
    h. Other reasons, after consultation with the Manager of CM/DM, plan Medical Director, the Primary Care Physician, and caregiver, as applicable, and may include following:
        i. Member refuses psychosocial services that are necessary to successfully participate in the CCM program.
        ii. Member is repeatedly or consistently not compliant with Plan of Care.
        iii. Determination by the CM staff that he/she is no longer able to provide services in a constructive manner, e.g., member is threatening to CM staff.
        iv. Any other case reviewed where benefit of CCM is not being attained after a considerable period of time (over a year).
2. The Care Plan's short and long term goals and accompanying interventions will drive the evaluation of the case. CM staff will review on a routine basis, prompted follow up tasks within the Clinical Information System to evaluate progress on individual cases. The CM/DM Director will review reports from the Clinical Information System regarding case progress and also intervene as necessary.
3. In general, CM staff will strive to complete short term interventions within thirty days of completion of Care Plan and for long term interventions within 90 days.
4. Barriers to achievement of the goals should be documented within the Clinical Information System.
5. Cases that fail to close within 90 days will be reviewed at Case Rounds as scheduled by the Manager of CM/DM. At that time, the case may be extended for an additional time defined period, but no greater than 90 additional days. After this period, if the case is still opened, the case will return to Case Rounds for review.
6. During the last contact with the member, the CM staff will ~~ask if he/she could complete~~mail out a case closure letter which includes a brief satisfaction survey about their experience with the case management services. ~~If the member agrees, the CM will mail a survey to the member for completion.~~ Once returned the survey will be inputted into Clinical Information System for analysis.
7. To close a case, the CM will select the case for closure and then select Start Case Closure. Any relevant details to the case closure are also documented. All tasks

associated with that case must be closed to proceed with the case closure process. Any intervention tasks must be closed from the Care Plan.

8. Follow up services should be arranged that ensure continuity of care and allow for closure of the case. The CM staff should include these within the Plan of Care as a new short term intervention.

9. The CM staff will participate in case reviews and case audits to evaluate individual performance and improve the services provided to Alliance members.

DEFINITIONS

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.

Care Plan Barriers: Issues that could impede the progress in completing a care plan goal.

Care Plan Goal: Goals are specific aims to which the Care Plan is directed. Goals are measureable and are based on the assessment of the member's needs.

Care Plan Intervention: Interventions are strategies or actions taken to assist the member in achieving their goals.

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. (NCQA).

AFFECTED DEPARTMENTS/PARTIES

Case and Disease Management

RELATED POLICIES AND PROCEDURES

CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
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

Complex Case Management (CCM) Program Description

REVISION HISTORY

12/05/2012, 03/01/2016, 09/06/2018, 04/16/2019, 04/24/2020, 5/21/2021, 03/22/2022, 6/20/2023, 6/12/2024

REFERENCES

1. NCQA QI 5: Complex Case Management
~~2. Clinical Information System User Guide v. 5.3~~

Commented [AL2]: TruCare reference necessary? If so, consider removing version number

MONITORING

The Chief Medical Officer, Sr. Director, Health Care Services, Director, ~~Case and Disease Management~~Social Determinants of Health, and Manager of Case and Disease Management regularly reviews:

1) Timeliness of Case Closure Reports from Clinical Information System
2) Progress of Cases at Case Rounds
3) Care Plan audits using NCQA file review forms

POLICY AND PROCEDURE

Policy Number	CM-006
Policy Name	Internal Audit and Monitoring
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	MCAL
Effective Date	01/04/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

In connection with any of its product lines, Alameda Alliance for Health (The Alliance) Case Management Department will conduct ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state statutory, regulatory, contractual, and National Committee for Quality Assurance (NCQA) accreditation requirements. It is the responsibility of the entire management team to ensure ongoing auditing and monitoring is properly executed, documented, and evidenced.

The Alliance must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, to evaluate internal compliance with regulatory, contractual and accreditation requirements and the overall effectiveness of the compliance program.

The Alliance will establish a monitoring process to rapidly detect potential issues and establish and implement an effective system to identify compliance risks. This includes:

- Routine internal monitoring of compliance risk areas
- Routine internal monitoring
- Periodic internal auditing to confirm results of monitoring

The Alliance will maintain processes to perform monitoring of key reporting requirements and assist in identifying areas that may qualify for “self-reporting” due to over or under performance metrics.

The Alliance Health Care Services Department is responsible for the oversight of the monitoring and auditing efforts for Utilization Management and Case Management (CM). The Alliance's Compliance Committee is responsible for the compliance activities of the organization and will receive reports regarding performance, updates to processes through the Utilization Management Committee to the Compliance Committee.

PROCEDURE

1. Health Care Services (HCS) staff will participate with Compliance in the annual audits of Alliance delegated Providers. HCS will audit and monitor the Providers' compliance with state and federal laws and regulations, The Alliance policies, procedures, contractual requirements, and NCQA accreditation requirements related to functions including but not limited to case management and utilization management.

2. Case Management leadership staff will develop and maintain a monitoring plan for the Case Management Department. The monitoring plan details monitoring reports, performance indicators, monitoring methods and monitoring frequency.

3. Monitoring reports will be identified based on internal, regulatory, contractual and accreditation standard requirements. At least annually, and as needed, reports will be identified along with the applicable performance metrics:
    3.1 Case Management Leadership will assess the various types of reports required for Case Management.

4. Case Management will identify appropriate performance benchmarks or indicators to assess compliance with applicable laws, regulations, and company policies. Examples of possible performance indicators include initiation of assessment, completion of assessment, completion of care plan, etc.

5. Monitoring methods are determined by the type of report and the performance indicators. Examples include risk assessments, data reviews, charts, graphics, spot checks, random sampling, staff interviews, etc.

6. Monitoring frequency is defined by regulation, contract or department policy but should be appropriate to the nature of the process and relative risk it represents. Examples:
    6.1 ~~Weekly~~ Monthly to ensure compliance is met for Complex Case Management assessment timeframes.
    6.2 Monthly ~~or quarterly~~ to determine compliance with Case Management assessment completion with required timeframe.
    6.3 Monthly to determine compliance with quality of cases, including call monitoring and reviewing documentation in the system of record
    ~~6.3~~6.4 Quarterly for Health Risk Assessment completion within the required timeframes.
    ~~6.4~~6.5 Annually for programmatic reporting.

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~~For Complex Case Management (CCM)~~

7. Case Auditing

7.1 CM Leadership~~HCS Staff~~ will randomly select ~~5~~ 3 ~~complex CCM~~ files per reviewer per case type

7.2 Case Types include (but are not limited to):

i. Transitional Care Services (TCS)

ii. Care Coordination

~~7.~~iii. Complex Case Management (CCM) (For RNs only)

~~7.1~~7.3 If ~~5~~ 3 files are unable to be selected, all ~~CCM~~ files of the case type are selected per reviewer

i. CCM - 100% of the files are reviewed using the NCQA worksheet or approved CCM file review tool

ii. ~~CCM cases~~Cases review for the timeliness of the assessment, the specific documentation of the core assessment elements as noted in the CM-001-Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment policy.

iii. For all other case types – 100% of the files are reviewed using the audit tool

- The audit tool includes the following but is not limited to:
  - Addressing the referral timely
  - Completion of appropriate assessment(s)
  - Linking appropriate pieces to the case (notes, assessments, authorizations, etc.)
  - Timely follow-up on the case
  - Appropriate letters/notifications sent out (case closure letter, educational materials if appropriate, etc.)

8. Phone Call Auditing

8.1 CM Leadership will review phone calls associated with randomly selected cases as described above

8.2 If no phone calls were made during the audit window, another phone call will be selected

~~ii.~~ Phone calls will be reviewed to confirm documentation is accurate with the system of record

8.3

~~8.~~ ~~For~~ Health Risk Assessment

9.

~~9.~~9.1 Each month Case Management Leadership will randomly select up to 2 HRA files per staff person.~~.~~

i. 100% of the files are reviewed using directions identified in the most recent All Plan Letter (APLs) for HRAs for SPD beneficiaries. File review will be completed using an approved HRA assessment Tool.

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ii. HRA files are reviewed for the timeliness of the assessment, the specific documentation of the core assessment elements as noted in the APL and CM-008, Policy and Procedure, SPD HRA – Survey and Interventions policy. If member is noted as High Risk, the file should contain the assessment by a clinician, individualized care plan, care team discussions and communication with the PCP.

Follow up and corrective actions

10. Any monitoring result indicative of a potential issue, problem or noncompliance must be adequately and timely addressed.
~~10.~~10.1 All monitoring is discussed routinely with individual staff

11. Case Management Leadership ~~Staff~~ is responsible for identifying issues/problems found in the monitoring activities and reporting it to the Director, Social Determinants of Health for recommendations/corrective actions.

12. Non-compliance monitoring results may be reported to the Sr. Director, Health Care Services. Based on the scope and severity of the issues, the Sr. Director, Health Care Services may notify the Compliance Officer for recommendations of the next appropriate steps.

    a. Non-compliance monitoring results may trigger a targeted or focused audit
    b. When there are severe monitoring results (repeat deficiencies or Immediate Corrective Action required), the Compliance Officer and Sr. Director, Health Care Services will follow action recommendations as defined in Compliance policies.

~~13.~~ Monthly reports of the monitoring activities will be reported to the Dr. Director, Health

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Care Services.

~~14.~~13. Repeat deficiencies or Immediate Corrective Actions Required are identified which impact member safety are reported expeditiously to the Chief Medical Officer for recommendations.

DEFINITIONS / ACRONYMS

Auditing: Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures.

Internal Audits: Internal Audits are audits of the Alliance or delegates conducted by an employee or by an affiliate of the Alliance.

Monitoring Activities: A process of regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Oversight: Oversight means monitoring and directing a set of activities, resulting in a desired outcome.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

Case Management
Compliance Department

RELATED POLICIES AND PROCEDURES

CM-001 –Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
CM-008, Policy and Procedure, SPD HRA – Survey and Interventions

REVISION HISTORY

01/04/2018, 04/16/2019, 05/21/2020, 3/22/2022, 6/20/2023, 6/12/2024

REFERENCES

~~APL 17-001~~
~~DHCS Two Plan Model Contract~~

APL-17-001

MONITORING

Monthly monitoring report for UM authorizations and processing turn-around-time.
Monthly monitoring HRA
Monthly monitoring Complex Case Management~~t~~

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POLICY AND PROCEDURE

Policy Number	CM-006
Policy Name	Internal Audit and Monitoring
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	MCAL
Effective Date	01/04/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

POLICY STATEMENT

In connection with any of its product lines, Alameda Alliance for Health (The Alliance) Case Management Department will conduct ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state statutory, regulatory, contractual, and National Committee for Quality Assurance (NCQA) accreditation requirements. It is the responsibility of the entire management team to ensure ongoing auditing and monitoring is properly executed, documented, and evidenced.

The Alliance must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, to evaluate internal compliance with regulatory, contractual and accreditation requirements and the overall effectiveness of the compliance program.

The Alliance will establish a monitoring process to rapidly detect potential issues and establish and implement an effective system to identify compliance risks. This includes:

- Routine internal monitoring of compliance risk areas
- Routine internal monitoring
- Periodic internal auditing to confirm results of monitoring

The Alliance will maintain processes to perform monitoring of key reporting requirements and assist in identifying areas that may qualify for “self-reporting” due to over or under

performance metrics.

The Alliance Health Care Services Department is responsible for the oversight of the monitoring and auditing efforts for Utilization Management and Case Management (CM). The Alliance's Compliance Committee is responsible for the compliance activities of the organization and will receive reports regarding performance, updates to processes through the Utilization Management Committee to the Compliance Committee

PROCEDURE

1. Health Care Services (HCS) staff will participate with Compliance in the annual audits of Alliance delegated Providers. HCS will audit and monitor the Providers' compliance with state and federal laws and regulations, The Alliance policies, procedures, contractual requirements, and NCQA accreditation requirements related to functions including but not limited to case management and utilization management.

2. ~~MM~~ ~~HCS~~ Case Management leadership staff will develop and maintain a monitoring plan for the ~~respective Health Services~~ Case Management Department~~s~~. The monitoring plan details monitoring reports, performance indicators, monitoring methods and monitoring frequency.

3. Monitoring reports will be identified based on internal, regulatory, contractual and accreditation standard requirements. At least annually, and as needed, reports will be identified along with the applicable performance metrics:
   3.1 ~~Health Care Services~~ Case Management Leadership will assess the various types of reports required for ~~Utilization Management/~~Case Management.
   ~~3.2 Pharmacy Director will identify pharmacy requirements~~
   ~~3.3 Behavioral Health will identify behavioral health requirements~~

4. ~~Each department~~ Case Management will identify appropriate performance benchmarks or indicators to assess compliance with applicable laws, regulations, and company policies. Examples of possible performance indicators include ~~process turn-around times~~initiation of assessment, ~~timeliness and appropriateness of member notices, correctness of decisions~~completion of assessment, completion of care plan, etc.

5. Monitoring methods are determined by the type of report and the performance indicators. Examples include risk assessments, data reviews, charts, graphics, spot checks, random sampling, staff interviews, etc.

6. Monitoring frequency is defined by regulation, contract or department policy but should be appropriate to the nature of the process and relative risk it represents. Examples:
   ~~6.1 Daily Notice of Action denial reasons to ensure the reason is clear and concise and understandable by the member.~~
   ~~6.2~~6.1 Weekly to ensure compliance is met for ~~expedited determinations~~Complex Case Management assessment timeframes.
   ~~6.3~~6.2 Monthly or quarterly to determine compliance with Case Management assessment completion with required timeframe.
   ~~6.4~~6.3 Quarterly for Health Risk Assessment completion within the required timeframes.
   ~~6.5~~6.4 Annually for programmatic reporting.

Commented [AL1]: what does "MM" stand for?

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~~For Adverse Benefit Determinations (ABD)~~

~~7. HCS Staff will generate report from the Clinical Information System of all determination, approved or denied, for the specific timeframe.~~

~~7.1 HCS Staff will randomly select 20 files per reviewer (10 approved and 10 denied).~~

~~7.1.1 100% of the files are reviewed using the NCQA worksheets or the approved UM file review tool~~

~~7.1.2 Approval files are assessed for the timeliness of decision making, the appropriate decision maker and communication to the member and provider~~

~~7.1.3 Denied files are assessed all items noted in Section 7.1.2 and clear and concise denial reason, criteria cited, regulatory rationale cited, appropriate documentation of clinical decision making, appropriate professional, correct ABD template with appeal right~~

Commented [AL2]: please request Michelle Findlater and Kimberly Glasby review this section re: internal UM audits. Does this apply to ECM and CS, as well?

For Complex Case Management (CCM)

~~8.~~7. HCS Staff will randomly select 5 complex CCM files per reviewer

~~8.1~~7.1 If 5 files are unable to be selected, all CCM files are selected per reviewer

i. 100% of the files are reviewed using the NCQA worksheet or approved CCM file review tool

ii. CCM cases review for the timeliness of the assessment, the specific documentation of the core assessment elements as noted in the CM-001-Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment policy.

For Health Risk Assessment

~~9.~~8. ~~HCS staff~~ Each month Case Management Leadership will randomly select up to ~~20~~2 HRA ~~files from newly enrolled members within the 120 days of enrollment into the Plan~~files per staff person..

Commented [AL3]: confirm this is still accurate? if so, are HRA audit results presented at UMC?

i. 100% of the files are reviewed using directions identified in the most recent All Plan Letter (APLs) for HRAs for SPD beneficiaries. File review will be completed using an~~d~~ approved HRA assessment Tool.

ii. HRA files are reviewed for the timeliness of the assessment, the specific documentation of the core assessment elements as noted in the APL and CM-008, Policy and Procedure, SPD HRA – Survey and Interventions policy. If member is noted as High Risk, the file should contain the assessment by a clinician, individualized care plan, care team discussions and communication with the PCP.

Follow up and corrective actions

~~10.~~9. Any monitoring result indicative of a potential issue, problem or noncompliance

must be adequately and timely addressed.

~~11.~~10. ~~HCS~~ Case Management Leadership Staff is responsible for identifying issues/problems found in the monitoring activities and reporting it to the Director, Social Determinants of Health ~~of Health Care Services (Director), Director, Utilization Management, or Director, Long Term Services and Supports,~~ for recommendations/corrective actions.

~~12. HCS Staff is responsible for maintaining and following up on corrective actions plans (CAPs).~~

~~a. CAPs should identify the non-compliance, identify the issue, establish a goal, provide a root cause of the issue, and identify remedies to resolve the deficiency along with timeframes.~~

~~b. CAPs are monitored as defined in Policy.~~

~~c. Internal units not able to resolve identified issues are or meet the CAP deadlines are reported to the Director.~~

~~13.~~11. Non-compliance monitoring results may be reported to the Sr. Director, Health Care Services. Based on the scope and severity of the issues, the Sr. Director, Health Care Services ~~may~~ notify the Compliance Officer for recommendations of the next appropriate steps.

a. Non-compliance monitoring results may trigger a targeted or focused audit
b. When there are severe monitoring results (repeat deficiencies or Immediate Corrective Action required), the Compliance Officer and Sr. Director, Health Care Services ~~will~~ follow action recommendations as defined in Compliance policies.

~~14.~~12. Monthly reports of the monitoring activities will be reported to the ~~Internal Compliance Committee~~Dr. Director, Health Care Services.

~~15.~~13. Repeat deficiencies or Immediate Corrective Actions Required are identified which impact member safety are reported expeditiously to the Chief Medical Officer for recommendations.

DEFINITIONS / ACRONYMS

Auditing: Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures.

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Monitoring Activities: A process of regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Oversight: Oversight means monitoring and directing a set of activities, resulting in a desired

outcome.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

Case Management
Compliance Department

RELATED POLICIES AND PROCEDURES

~~UM-051 – Timeliness of UM Decision~~
CM-001 –Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
CM-008, Policy and Procedure, SPD HRA – Survey and Interventions

REVISION HISTORY

01/04/2018, 04/16/2019, 05/21/2020, 3/22/2022, 6/20/2023, 6/12/2024

REFERENCES

APL-17-001
DHCS Two Plan Model Contract

MONITORING

Monthly monitoring report for UM authorizations and processing turn-around-time.
Monthly monitoring HRA
Monthly monitoring Complex Case Management

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POLICY AND PROCEDURE

Policy Number	CM-007
Policy Name	SPD Health Risk Initial Stratification
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL, IHSS
Effective Date	6/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

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POLICY STATEMENT

OVERVIEW

Alameda Alliance for Health (the Alliance) provides an assessment of every newly enrolled Seniors and Persons with Disabilities (SPD) member through a process that differentiates members who are at high or low risk for medical complications, deteriorating health conditions or in need of special assistance from the Alliance, mental health, or community-based services.

To ensure that the appropriate level and quality of care is delivered to newly enrolled, non-dual SPD members, the Alliance makes every effort to identify each member's individual medical, behavioral health, and resource needs.

POLICY

The Alliance uses two processes to identify the relative health risk for each new SPD member. The first process is an initial risk stratification mechanism that analyzes health care utilization data received from DHCS and, when available, Health Information Form/Member Evaluation Tool (HIF/MET) information and Alliance medical history data. This data represents the SPD member's prior health care utilization under Medi-Cal Fee-for-Service (FFS). For risk stratification purposes, "higher risk" means Medi-Cal members who are at an increased risk of having an adverse health outcome or worsening of their health status if they do not have an individualized care management plan.

The Alliance completes this initial stratification within 44 calendar days of enrollment. When there is no data to determine the member's risk category, the member is identified as low risk.

PROCEDURE

1. Initial stratification of SPD Members
   A. Initial stratification is completed within 44 calendar days of enrollment for all non-dual, SPD members.
   B. The Alliance uses multiple data sources to stratify members' health risk including members' historical Medi-Cal FFS utilization data provided by DHCS at the time of enrollment. This data may include, but is not limited to, outpatient, inpatient, emergency department, and ancillary services data for the most recent 12 months.
   C. The data sources are used to systematically stratify members as either high risk or low risk per Stratification Algorithm:
      (1) Higher risk individuals include but are not limited to members who:
         (a) Have been on oxygen within the past 90 days
         (b) Are residing in an acute hospital setting
         (c) Have been hospitalized within the last 90 days, or have had three (3) or more hospitalizations within the past year
         (d) Have had three (3) or more emergency room visits in the past year
         (e) Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness)
         (f) Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant
         (g) Have cancer, and are currently being treated
         (h) Are pregnant
         (i) Have been prescribed antipsychotic medication within the past 90 days
         (j) Have been prescribed 15 or more prescriptions in the past 90 days
         (k) Have a self-report of a deteriorating condition
      (2) Stratification Algorithm
         (a) Members that meet at least one of the criteria listed in 1.c.1. are stratified as initial high risk
         (b) Members that do not meet any of the criteria listed in 1.c.1. are stratified as initial low risk.
   D. The Alliance stratifies members who lack Medi-Cal FFS utilization or HIF/MET data into higher or lower risk groups within 44 days.
      (1) When DHCS utilization data is not available, but the HIF/MET responses are present, the Alliance will use a HIF/MET scoring methodology below to stratify new member health risk.
         (a) Each question is weighted and allows for one point for each "yes" response to Questions 1 through 9.
         (b) Question 10 is weighted using one point for each of the 13 chronic conditions.
         (c) Total potential scoring: 22
         (d) Stratification of Newly Enrolled SPD members using the HIF/MET data only iscalculated by adding the points from the HIF/MET:
            (i) High Risk – 15 points and above
            (ii) Low Risk – 14 points and below

(2) Newly enrolled SPD Members with no DHCS FFS utilization data and no HIF/MET profile will be stratified as lower risk.

2. Validation of Stratification Scoring Methodology
   A. Twice a year, during the months of March and September, Case Management will randomly pull 30 members from the dashboard
      (1) 15 members will be initially stratified as high risk.
      (2) 15 members will be initially stratified as low risk.
   B. Case Management staff will populate the audit tool with the following information:
      (1) Case #: The cases pulled for the audit will be labeled 1-30 to identify them within the audit tool.
      (2) Member #: Member HealthSuite ID number
      (3) Initial Risk Category: Member initial risk as determined by Stratification Algorithm and found in the HRA dashboard.
      (4) High Risk Criteria Met: Evidence of criteria as listed in 1.c.1. This will be presented as one of the following:
         (a) High Risk Criteria Met
         (b) Low Risk – No High Risk Criteria Met
      (5) Pass (1) or Fail (0)
         (a) Pass: If Initial Risk Category matches findings
         (b) Fail: If Initial Risk Category does not match findings
   C. Report will auto calculate compliance rate to be shared at Utilization Management Sub-Committee meetings following audit completion date. Findings will be shared with Healthcare Analytics. In the event that the compliance rate falls below 100%, Healthcare Analytics will develop a plan within a month of receiving the report to correct any error and the process will be retested until the audit shows a compliance rate of 100%.

DEFINITIONS

Health Risk Assessment (HRA) Risk Stratification: Mechanism or algorithm designed for identify newly enrolled members

High Risk: MediCal members who are at increased risk of having adverse health outcome or worsening of their health status if they do not have an individualized care management plan

Lower Risk: MediCal members who need basic care management.

This classification methodology is consistent with the guidelines defined in Department of HealthCare Services (DHCS) All Plan Letter: ~~17-013 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities~~22-024 Population Health Management Policy Guide.

Commented [AL1]: 17-013 is retired; change reference to APL 22-024, which establishes the PHM Policy Guide as the source for the HRA guidance

AFFECTED DEPARTMENTS/PARTIES

Health Care Analytics
Utilization Management
Case Management
Quality Improvement

RELATED POLICIES AND PROCEDURES

CM-001 Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
CM-008 SPD Health Risk Assessment – Stratification and Interventions

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Health Risk Assessment
Health Information Form/Member Evaluation Tool (HIF/MET)

REVISION HISTORY

1/2012, 3/1/2016, 1/4/2018, 3/21/2019, 4/16/19, 05/21/2020, 03/22/2022, 6/20/2023, 6/12/2024

REFERENCES

DHCS Contract, Exhibit A, Attachment 10
DHCS All Plan Letter~~17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities~~ 22-024 Population Health Management Policy Guide.
Welfare & Institutions Code § 14182

MONITORING

The timeliness of HRA administration is monitored by the following:

- Daily and Monthly HRA Completed by User Report.
- Reporting to DHCS as required.

Stratification is monitored through bi-annual auditing.

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POLICY AND PROCEDURE

Policy Number	CM-019
Policy Name	Private Duty Nursing Case Management For Members under the age of 21
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL, IHSS
Effective Date	09/17/2020
Subcommittee Name	~~Quality~~ Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

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POLICY STATEMENT

~~EPSDT~~ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) also known as Medi-Cal for Kids & Teens is a benefit that provides a comprehensive array of preventive, diagnostic, and treatment services, including but not limited to case management, for individuals under the age of 21. The Alliance (MCP) will provide case management services to members under the age of 21 who have approved Private Duty Nursing (PDN) services whether or not the Alliance is financially responsible for those services. PDN services may be obtained through Home Health Agencies, individual nurse providers (INP) or other entities, such as California Children's Services (CCS) or any combination thereof to meet the member's needs.

Commented [AL1]: add reference to DHCS' current language for EPSDT (ie: "Medi-Cal for Kids and Teens")

PROCEDURE

1. When an eligible member under the age of 21 is approved for PDN by the Alliance or CCS, a referral will be made to Case Management per the Alliance normal workflow.
2. When the Alliance has approved a plan enrolled EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services, the Alliance retains primary responsibility to provide Case Management for approved Private Duty Nursing services.
3. When CCS has approved a CCS participant who is an EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services for treatment of a CCS condition, the CCS Program has primary responsibility to provide Case Management for approved Private Duty Nursing services.
4. Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved Private Duty Nursing services, an EPSDT eligible

Medi-Cal beneficiary approved to receive Medi-Cal Private Duty Nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be the Alliance, CCS, or the Home and Community Based Alternatives Waiver Agency) to request Case management for Private Duty Nursing services. The contacted Medi-Cal program entity must then provide Case Management Services as described above to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for Case Management.

5. Case management will reach out to the member once services are approved to:
    - provide the member with information about the number of PDN hours the member is approved to receive
    - coordinate services with the entity providing services for the member
    - assisting Non-contracted providers with the process of enrolling to become a Medi-Cal member if needed
    - coordination of services if multiple providers are required to manage the member's PDN needs
6. If a member elects to not use all of the approved PDN services, the Alliance will document such within the members record with all applicable information

DEFINITIONS / ACRONYMS

Case Management Services: means those services furnished to assist individuals eligible under the Medi-Cal State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.18 and 440.169. The assistance that case managers provide in assisting eligible individuals is set forth in 42 CFR 14 section 440.169(d) and (e), and 22 California Code of Regulations (CCR) section 51184(d), (g) (5) and (h). SA Pg. Pg. 3, para. 1.

EPSDT services: means Early and Periodic Screening, Diagnostic and Treatment services, (also called Medi-Cal for Kids and Teens,) a benefit of the State's Medi-Cal program that provides comprehensive, preventative, diagnostic, and treatment services to eligible children under the age of 21, as specified in section 1905(r) of the Social Security Act. (42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).)

Private Duty Nursing (PDN): means nursing services provided in a Medi-Cal beneficiary's home by a registered nurse or a licensed practical nurse, under the direction of a beneficiary's physician, to a Medi-Cal beneficiary who requires more individual and continuous care than is available from a visiting nurse. (42 CFR. § 440.80.)

Home Health Agency: as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.

Individual Nurse Provider (INP) means: a Medi-Cal enrolled Licensed Vocational Nurse or Registered Nurse who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.

CCS: California Children Services

AFFECTED DEPARTMENTS/PARTIES

Utilization management
Case Management
Claims

RELATED POLICIES AND PROCEDURES

UM-017 Home and Community Based Services (Waiver Programs) - DDS

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

9/17/2020, 1/21/2021, 03/22/2022, 6/20/2023, 6/12/2024

REFERENCES

APL 20-012
Social Security Act (SSA), section 1905(r) and Title 42 of the United States Code (USC), section 1396d(r).

MONITORING

Annually

POLICY AND PROCEDURE

Policy Number	CM-028
Policy Name	Disease Management – Home Placed Developmentally Disabled (HPDD) Members
Department Name	Health Care Services
Department Owner	Director, Social Determinants of Health
Lines of Business	MCAL
Effective Date	9/22/2008
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

POLICY STATEMENT

In conjunction with Regional Center for the East Bay (RCEB), Alameda Alliance for Health (Alliance) provides Case Management and Disease Management services to Agnews Transitional Consumers now known as Home Placed Developmentally Disabled (HPDD) Members.

Commented [AL1]: how are these members identified in TruCare?

HPDD members will receive all services available to Alliance Medi-Cal members for which they qualify, including Disease Management, Case Management, and Health Education.

PROCEDURE

1) The Alliance Regional Center for the East Bay (RCEB) liaison will:
   a) ~~Review the case management database on~~Communicate the case and disease management program available for all HPDD members to ~~identify members who qualify for inclusion in a disease management program~~RCEB.
   b) ~~Refer any HPDD qualifying members to Regional Center of the East Bay, (RCEB), if not already participating~~Assist RCEB as needed in referring HPDD members into case and disease management.
   c) HPDD members identified will enroll in the appropriate case/disease management program and will receive all services provided through the appropriate case/disease management program. Services may include:

i) Telephonic interventions to ensure members receive appropriate preventive care and are complying with evidence-based clinical treatment guidelines;

~~ii) Post card reminders of preventive services and up-coming medical appointments;~~

~~iii)~~ii) Health education materials supportive of member self-management of chronic disease conditions;

~~iv) Coordination of specialist referrals as needed. Periodically review members participating in the case/disease management program to determine continued eligibility based on successful engagement of the member with the program.~~

~~2) Additional RCEB liaison responsibilities include:~~

~~a) Communicate regularly with RCEB PCP or treating physician, RCEB staff and HPDD Home Administrators regarding any change in the status of the member's participation in a case/disease management program and assisting with coordination of the member's care.~~

~~b) Discuss individual cases on a regular basis with the Alliance Medical Director and Director for Health Care Services using measurable outcomes to assess case progress and evaluate the quality and cost of Disease Management.~~

~~c) Report Disease Management activities to the Alliance Medical Director and Senior Director for Medical Services.~~

Commented [AL2]: do these processes happen today? If so, where are they tracked?

Commented [AL3]: correct the footer to "CM" policy instead of UM

DEFINITIONS

Disease Management: A coordinated program of preventive, diagnostic, and therapeutic measures intended to provide cost-effective, quality healthcare for a patient population who have or are at risk for a specific chronic illness or medical condition. Also known as disease state management.

Case Management: A collaborative process involving assessment, planning, and implementation of services required to meet a member's ongoing health care needs with the goal of achieving the best possible outcomes for each individual across a continuum of care.

Regional Center of the East Bay (RCEB): A program established to provide non-medical services for members with substantial developmental disabilities. RCEB serves Alameda and Contra Costa Counties.

Individual Health Care Plan (IHCP): The initial health care plan created by the HPDD Case Manager and the HPDD Primary Care Physician (PCP) working with the Consumer's Agnews Primary and Specialty Care Physicians, RCEB, and other involved persons that identifies the Consumer's health care conditions (past and present) medications, known allergies, most recent medical exams and evaluations, identified risks, medical supply and equipment needs, activities of daily living and recommended transition activities.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. 22CCR§ 51185, 51351; DHCS Contract, Attachment 11
2. HPDD Workflows

REVISION HISTORY

1/16/2009, 11/9/2010, 9/7/2012, 4/2/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 6/28/2022, 6/20/2023, 6/12/2024

REFERENCES

None

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	CM-030
Policy Name	Early Start
Department Name	Case and Disease Management
Department Chief	Chief Medical Officer
Department Owner	Director, Social Determinants of Health
Lines of Business	Medi-Cal
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

POLICY STATEMENT

A. The California Early Intervention Services Act implements the State's interagency early intervention service program, known as Early Start, for children with developmental delayed disabilities or those at high risk for developmental disabilities, who are from birth to 36 months of age.

B. Primary Care Providers (PCP) 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.

C. PCPs and the Alliance are responsible for providing and/or arranging all medically necessary diagnostic, specialty or therapeutic services to evaluate, correct and/or ameliorate a suspected or confirmed condition.

D. 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.

E. The Alliance will provide case management and care coordination to the member to ensure provision of all medically necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start Program, with PCP participation. The Alliance is responsible for facilitating working relationships between PCPs and the RCEB as needed, resolving any disputes between PCPs and the RCEB and for arranging appropriate training for PCP staff regarding the Early Start

Program.

PROCEDURE

Identification of Members and Referral to RCEB

A. Children, birth to three years of age, in need of early intervention services due to established, suspected, or are at risk for conditions leading to developmental delay, must be referred to the RCEB for evaluation for the Early Start Program. These children would include those:
    1. With a condition known to lead to developmental delay;
    2. In whom a significant developmental delay is suspected; or
    3. Whose early health history places them at risk for delay.

B. Infants and toddlers from birth to 36 months old may be eligible and benefit from early intervention services if significant delay is present in one or more of these areas:
    1. Cognitive development
    2. Physical and motor development
    3. Communication development
    4. Emotional-social development
    5. Adaptive development

C. Members may also qualify for early intervention services if there are established risk conditions known to result in developmental delays/disabilities:
    1. Chromosomal disorders
    2. Inborn errors of metabolism
    3. Neurological disorders
    4. Visual and hearing impairments

D. Members at high risk for having a substantial developmental disability due to a combination of biomedical risk factors may also qualify.
    1. PCPs may identify Members in any of the categories above through:
        a. Developmental assessments performed as part of a Well Child exam.
        b. Evaluation of children noted to have possible developmental delay by parents, guardians, school officials, or other contacts.
        c. Other medical encounters that generate suspicion of developmental delay for the Member.
    2. Alliance Utilization Management (UM) and Case Management (CM) staff may identify Members in any of the categories above through:
        a. PCP requests for specialty or diagnostic referrals that suggest developmental delay or one of the conditions associated with developmental delay.
        b. Requests for evaluation from school official, parents, RCEB or other sources regarding possible developmental delay.
        c. PCPs or Alliance UM/CM staff that identify Members who meet any of the

potential eligibility criteria above must refer those Members to the RCEB Early Start Program. If a PCP makes the referral directly, they must inform the Alliance. The referral must be accomplished within two working days of determining the potential or actual need for services. The phone number and address of the local RCEB is:

Alameda County RCEB
Regional Center of the East Bay San Leandro Main Office 500 Davis Street, Suite 100 San Leandro, CA 94577 Phone: (510) 618-6100 Fax: (510) 678-4100

To refer:

For children 3 years old and under:

Early Start Program

Phone: 510-618-6195

Fax: 510-678-4156

Email: EarlyStartReferrals@rceb.org

E. The RCEB has 45 days from the receipt of a referral to determine a child's eligibility and assessment for services. When a Member is receiving services from RCEB, Alliance CM is responsible for ensuring that medical and health assessment information is provided to the RCEB's Early Start Program as needed. The PCP or other specialist must submit documentation to the RCEB's Early Start Program that includes but is not be limited to:

1. Specific physical findings;
2. Diagnostic and laboratory and radiological test results;
3. Developmental assessments including hearing and vision; and
4. Recommendations for therapies/interventions.

F. The RCEB determines if a referral should be made to the Local Education Agency (LEA). The PCP and Independent Practice Association (IPA) CM coordinate with the LEA as needed.

G. The RCEB notifies the referring entity once a child is determined to be eligible for services through the RCEB. RCEB provides families with an additional copy of the service plan to share with the PCP. PCPs who make direct referrals must inform Alliance CM if a child is determined to be eligible.

H. RCEB provides a variety of services through the Early Start Program. A listing of services can be found on the California Department of Developmental Services website, http://dds.ca.gov or Regional Center of the East Bay website, http://www.rceb.org

Primary Care and Specialty Referrals

I. PCPs are responsible for providing all primary care for Members with suspected or

confirmed developmental delay. Primary care services include:

1. Well Child exams including assessment of developmental status.
2. Illness or injury care.
3. Referral/authorization request for all medically necessary diagnostic, therapeutic or specialty practitioner services to diagnose a suspected condition or treat a confirmed condition.
4. Referral to RCEB Early Start Program as indicated above.
5. Consultation with RCEB or LEA staff regarding the Member's care plan as needed.

J. PCPs, with assistance from their Alliance UM/CM staff as needed, are responsible for referring Members with suspected or confirmed developmental delay for all medically necessary specialty diagnostic and/or treatment services including but not limited to:

1. Specialty diagnostic services to evaluate the Member's condition (e.g., CT or MRI scans, etc.);
2. Specialty practitioners for diagnosis or treatment (e.g., neurologists);
3. Referrals to psychologists or psychiatrists as needed;
4. Referral to other types of practitioners as needed (PT, OT, BHT, ST, etc.); and
5. All other specialty health care services as needed.

Case Management and Reporting

K. Alliance UM/CM staff are responsible for coordinating all medically necessary specialty care including:

1. In-network diagnostic, therapeutic or specialty practitioner services.
2. Out-of-network services as needed.
3. Referral and coordination of services rendered under Fee-For-Service Medi-Cal as needed, through CCS, Behavioral Health, or other practitioners.

L. Alliance UM/CM is responsible for arranging all necessary transfer of medical information including:

1. Facilitating PCP or specialist telephonic communication with RCEB or LEA staff as needed.
2. Transferring medical records, diagnostic test results or other hard copy medical information as needed.
3. Arranging case conferences with PCP, specialist and RCEB or LEA staff as needed.
4. Resolving any disputes between RCEB, PCP/specialists and/or IPA.
5. Other assistance as required.
6. Attend RCEB staff meetings as needed.

M. 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-042 for monitoring of delegation oversight.

DEFINITIONS

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 Directors - which includes individuals with developmental disabilities, family members and community leaders - provides guidance and leadership.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

1. UM-012 Care Coordination – Behavioral Health
2. UM-017 Waiver Programs
3. UM-020 Developmental Disabilities

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 6/1/2011, 8/30/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 3/22/2022, 6/28/2022, 6/20/2023, 6/12/2024

REFERENCES

1. DHCS Contract Exhibit A, Attachment 11, Provision 11

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	CM-031
Policy Name	School Linked ~~CHDP Services~~ Early and
Department Name	Case and Disease Management
Department Chief	Chief Medical Officer
Department Owner	Director, Social Determinants of Health
Lines of Business	Medi-Cal
Effective Date	12/5/2007
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/15/2024
Administrative Oversight Committee Approval Date	6/12/2024

POLICY STATEMENT

- The Alliance will coordinate with school-linked ~~CHDP~~ Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) (Medi-Cal for Kids & Teens) ~~Services~~ in order to assure access for child and adolescent members to preventive and early intervention services.
- All pediatric members will be assigned to a Primary Care Provider (PCP) who will be their "medical home."
- Members may choose to be assigned to a school based health center for primary care if that center is contracted with the Alliance as a PCP.

Commented [AL1]: given the CHDP transition, does this P&P need to be retired and/or updated to align with the activities that MCPs are now responsible for? (or does QI already have a policy that addresses this?)

https://www.dhcs.ca.gov/services/CHDP

PROCEDURE

1. All members are assigned to a primary care provider (their "medical home") who is responsible for coordinating their care.
2. When a child is assigned to a contracted primary care provider with a satellite school based health center, that primary care provider is responsible for providing the full scope of primary care as detailed in their primary care contract.
   a) The care may be provided in the school health center or at the parent clinic.
   b) That provider maintains full responsibility for the management of that member as detailed in their primary care contract.
3. When a member receives services from a school based health center which is not a contracted provider, the health center will be encouraged to do the following:
   a) Identify the student's health coverage
   b) Identify the primary care provider

c) Coordinate with the primary care provider as appropriate and with consent of the member
d) Make appropriate referrals for preventive care (including ~~CHDP services~~ Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) (Medi-Cal for Kids & Teens)), specialty care, mental health and public health services as necessary
e) Provide and bill the plan for the following:
   i) Family planning
   ii) STDs
   iii) HIV testing and counseling

4. School based health centers may call the Member Services or Case and Disease Management departments for assistance in coordinating a 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

~~CHDP: California Child Health Disability Prevention program.~~

School Linked ~~CHDP~~ Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) (Medi-Cal for Kids & Teens) ~~Services~~: Pediatric preventive health services obtained through a local school district or health facility located at a school.

LEA: Local Educational Authority, typically local school district.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

DHCS Contract, Exhibit A, Attachment 11, Provision 13

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 8/30/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/20/2023, 6/12/2024

REFERENCES

None

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	CM-032
Policy Name	Care Coordination – Local Education Agency Services
Department Name	Case and Disease Management
Department Chief	Chief Medical Officer
Department Owner	Director, Social Determinants of Health
Lines of Business	Medi-Cal
Effective Date	12/4/2007
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/15/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

POLICY STATEMENT

Services provided by Local Education Agencies (LEA) are not covered benefits under Medi- Cal Managed Care but are covered under Medi-Cal Fee-For-Service. LEA services are reimbursable by Medi-Cal Fee-For-Service for Alliance Medi-Cal Members pursuant to Title 22, CCR, §51535.5.

LEA services are provided to Members who meet LEA Program eligibility and are specified in Title 22, CCR, §51360 (b):

- Health and mental health evaluation.
- Physical therapy (PT), which consists of PT services as set forth in Title 22, CCR, §51309 (b), when provided by an LEA practitioner for an LEA eligible Member.
- Occupational therapy (OT), which consists of OT services as set forth in Title 22, CCR, §51309 (c), when provided by an LEA practitioner for an LEA eligible Member.
- Speech pathology or therapy (ST) and audiology services, which consist of ST services as defined by Title 22, CCR, §51096, and audiology services as defined by §51098 when provided by an LEA practitioner for an LEA eligible Member.
- Psychology and counseling services, consisting of diagnosis and psychological counseling of LEA eligible Members with identified mental health, substance abuse, behavioral adjustment, or social problems.
- Nursing services, consisting of preventative and medically necessary nursing

services rendered at the school site.

- School health aide services, consisting of the direct provision of specialized physical health care services rendered at the school site.
- Medical transportation, which consists of medical transportation as described in §51323.

LEA services are administered by local school districts and are provided to Medi-Cal Members who are under 22 years of age, enrolled in a school within an LEA in California, and who meet LEA Program eligibility.

PCPs are required to assist LEAs with the development of Individual Education Plans (IEP) for children 3 years of age and older or Individual Family Service Plans (IFSP) for children 0-3 years old, if needed.

Alliance Medi-Cal Members receiving LEA services remain enrolled in the Alliance and the Alliance and PCPs remain responsible for all other medically necessary covered health care.

PROCEDURE

A. Provider Services Department will educate PCPs of their responsibilities related to LEA services through the Provider Manual and other periodic communication as needed:

1. Identification of Members Potentially Eligible for LEA Services

   a. LEA services are provided primarily to those Members with an identified developmental disability which affects school performance.

   b. A Member's need for LEA services are determined primarily by the Member's PCP. The need for LEA services may also be identified by the Member, the Member's parent or other family members, or through a Member's encounter with a health care practitioner.

   c. If a PCP, specialist, or Member identifies the need for LEA services, the local school district must be contacted directly.

   d. Many school districts recommend that the referring practitioner provide medical records or a letter documenting the identified developmental disability and recommendations for treatment.

   e. The Member's local school district determines whether the Member is eligible for LEA services based on the Member's medical condition, with input from the PCP or referring practitioner.

2. Care Coordination Services

   a. Continuing all medically necessary health care other than the LEA services.

   b. Cooperating and collaborating with LEAs in the development of the IEP or IFSP, if needed.

   c. Ensuring the provision of covered medically necessary diagnostic, preventative and treatment services identified in the ICP or IFSP, with Alliance participation as needed.

B. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management

responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

Local Education Agency (LEA) is the governing body of any school district or community college district, the county office of education, a state special school, A CSU campus, or a UC campus. To participate as an LEA provider, the LEA must apply to the Medi-Cal program. LEAs employ or contract with qualified medical practitioners to provide health assessments and medical services, within their scope of practice, to Medi-Cal eligible children and, where appropriate, to their family members.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

1. DHCS Contract Exhibit A, Attachment 11
2. Title 22, CCR, Sections 51190.1, 51360 (b), and 51535.5
3. Education Code, Section 56340 et seq.
4. Government Code, Section 95020
5. DHCS MMCD Policy Letter 00-06

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

12/4/2007, 1/1/2008, 10/28/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 05/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 6/12/2024

REFERENCES

None

MONITORING

The Compliance and Case and Disease Management Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee, and Administrative Oversight Committee annually.

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POLICY AND PROCEDURE

Policy Number	CM-034
Policy Name	Transitional Care Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director of Social Determinants of Health
Lines of Business	MCAL, IHSS
Effective Date	01/01/2023
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~5/17/2024~~TBD
Administrative Oversight Committee Approval Date	~~8/21/2024~~TBD

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POLICY STATEMENT

Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC) settings.

Under Population Health Management (PHM) and in line with CalAIM, the Alliance is accountable for providing strengthened Transitional Care Services (TCS) beginning on January 1, 2023 and be fully implemented for all members by January 1, 2024 across all settings and delivery systems, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports. This is accomplished by ensuring that a single point of contact, herein referred to as a care manager, can assist members throughout their transition and ensure all required services are complete.

The transitional care policies are consistent with the DHCS' Comprehensive Quality Strategy (CQS) and are being measured through quality reporting. This includes ensuring timely follow-up for members with emergency department (ED) visits for mental health issues or SUD. The Alliance will implement future DHCS policy guidance ongoing.

The Alliance implements timely prior authorizations and when informed that members are admitted, discharged or transferred.
The Alliance also ensures that all TCS are complete (including assigning a care manager/single point of contact who will complete all required responsibilities) for all high-

risk members. For Transitional Care Services, high risk members are defined as the following populations:

- Any "high risk" members as identified through the Alliance's' RSS mechanisms or through the PHM Service once the statewide RSS and risk tiers are available;
- Any other populations who require assessments, including but not limited to:
    - Those who are in ECM or CCM (TCS must be provided by the ECM or CCM Care Manager); and
    - Those who received LTSS.

By January 1, 2024 the Alliance will ensure all TCS (as required below) are completed for all members.

PROCEDURE

Admission, Discharge, and Transfer (ADT)
The Alliance is responsible for knowing, in a timely manner, when all members have planned admissions, and when they are admitted, discharged, or transferred, and therefore experiencing a transition, through the following mechanisms:

- The Alliance is responsible for ingesting and utilizing ADT feeds when they exist.
- The Alliance enters agreements with all contracted general acute care hospitals and emergency departments, as defined by HSC § 1250 to received ADT notifications from them whenever their members are admitted, discharged or transferred, and request such notification in advance of the ADT Event, when possible.
- The Alliance provides up to date Member rosters to their contracted general acute care facilities, emergency departments, and skilled nursing facilities (together "Participating Facilities") so that such facilities can send notifications to the Alliance whenever one of their members is admitted, discharged or transferred to or from their facility.
    - To meet this expectation, The Alliance receives these ADT notifications from "intermediaries", defined as a health information exchange network, health information organization, or technology vendor that assists a "Participating Facility" in the Exchanged of Health and Social Services Information.
- When ADT feeds are not available (for example, many SNFs do not create ADT data feeds), the Alliance identifies other mechanisms or establishes other data-sharing agreements to know when members are expected to be/are admitted, discharged, or transferred. These can include but are not limited to requirements for notification by admitting facilities and institutions directly or leveraging existing prior authorization requests.

Prior Authorizations and Timely Discharges
The Alliance will ensure timely prior authorizations and discharges for all members, which includes, but is not limited to, ensuring that prior authorizations required for a member's discharge are processed in a timely manner.

Identification of High- vs. Lower-risk Transitioning Members
"High-risk" transitioning members means all members listed below:

- Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver).
- Those entering CCM (per NCQA).
- Those entering ECM.

- Children with Special Health Care Needs (CSHCN).
- Pregnant individuals.
- Seniors and persons with disabilities who meet the definition of "high risk" as established in existing APL requirements, namely:
    - Members who have been authorized to receive:
        - IHSS greater than, or equal to, 195 hours per month;
        - Community-Based Adult Services (CBAS), and/or
        - Multipurpose Senior Services Program (MSSP) Services.
    - Members who:
        - Have been on oxygen within the past 90 days;
        - Are residing in an acute hospital setting;
        - Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
        - Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
        - Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
        - Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
        - Have cancer and are currently being treated;
        - Are pregnant;
        - Have been prescribed antipsychotic medication within the past 90 days;
        - Have been prescribed 15 or more prescriptions in the past 90 days;
        - Have a self-report of a deteriorating condition; and
        - Have other conditions as determined by the MCP, based on local resources.

In addition to these groups, and in recognition of high risk of poor outcomes in transition for Alliance members enrolled in multiple payors, those transitioning from SNFs, and those at high risk who are potentially not captured by the above categories, the Alliance also considers the following members "high-risk" for the purposes of TCS:

- Any member who has been served by county SMHS and/or DMC or DMC-ODS (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by the MCP or discharging facility
- Any member transitioning to or from a SNF
- Any member that is identified as high risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS.

Alliance Oversight of Facility Discharge Planning Process

TCS requirements build on, rather than supplant, existing requirements on facilities. Hospitals must provide patient-centered discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation; national Joint Commission accreditation standards; and state statutory requirements; and certain similar requirements apply to SNFs.

The Alliance is accountable for providing all TCS in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as required by

federal and state requirements. The Alliance ensures discharging facilities complete a discharge planning process that:

- Engages members, and/or members' parents, legal guardians, or Authorized Representative, as appropriate, when being discharged from a hospital, institution or facility.
- Focuses on the member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
- Uses a consistent assessment process and/or assessment tools to identify members hwo are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals' current processes. Hospitals are currently already required to identify these members and complete a discharge planning evaluation on a timely basis, including identifying the need and availability of appropriate post-hospital services and documenting this information in the medical record for establishing a discharge plan.
    - For high-risk members, the Alliance ensures the discharging facility shares this information the Alliance's assigned care manager and that the discharging facilities have processes in place to refer members to ECM or Community Supports as needed.
    - For members not already classified as high-risk by the Alliance, the discharging facility must have processes in place to leverage the assessment to identify members who may benefit from high-risk TCS services. This process must include referrals to the Alliance for:
        - Any member who has a specialty mental health need or substance use disorder.
        - Any member who is eligible for an ECM Population of Focus
        - Any member whom the clinical team feels is high-risk and may benefit from more intensive transitional care support upon discharge.
- Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with facilities' current requirements.
- Ensures members and their caregivers are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner.
    - This must include a medication reconciliation upon discharge that includes education and counseling about the member's medications.
- Coordinates care with:
    - The member's designated family caregiver(s). The Alliance ensures they are notified of the member's discharge or transfer to another facility.
    - Post-discharge providers. The Alliance ensures they are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.

Care Manager Responsible for TCS

Once a member has been identified as being admitted, including SNFs, the Alliance identifies the care manager, who is the single point of contact responsible for ensuring completion of all

transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.

- This requirement applies to high-risk members starting on January 1, 2023, including members with long-term services and supports (LTSS) needs, those entering CCM, those entering ECM, Children with Special Health Care Needs (CSHCN), Pregnant individuals, and Seniors and persons with disabilities (SPD). This requirement applies to all members starting on January 1, 2024.
- For members enrolled in CCM or ECM, the Alliance ensures that the member's assigned ECM Lead Care Manager or CCM care manager is the care manager who must provide all TCS.
- "Longitudinal support" means that a single relationship must span the whole transition. For members not enrolled in ECM or CCM, this single point of contact ("care manager") does not need to be employed by the plan and can be provided by contracted entities (e.g. the primary care practice, an Accountable Care Organization or, the hospital). The Alliance ensures that a single point of contact is assigned until needs are met and that all TCS can be completed.
- Working with a care manager is optional for members. The Alliance ensures that the member is offered the direct assistance of the care manager, but members may choose to have limited or no contact with the care manager. In these cases, at a minimum, the Alliance ensures that discharging facilities comply with federal and state discharge planning requirements (listed above) and that the care manager assists in all care coordination among the discharging facility, the PCP, or any other identified follow-up providers, and the follow-up is complete.

Communication of Assignment to the Care Manager

The Alliance communicates both with the responsible care manager (or contracted care manager) and with the facility, including SNFs where the patient is admitted (referred to as the "discharging facility") in a timely manner so that the care manager can participate in discharge planning and support access to available services. This requirement applies to high-risk members starting on January 1, 2023, and to all members starting on January 1, 2024.

For members receiving TCS, their assigned care managers (including ECM and CCM) are notified within 24 hours of admission, transfer or discharge when an ADT feed is available or within 24 hours of the Alliance being aware of any planned admissions, or of any admissions, discharges or transfers for instances where no ADT feed exists (such as for SNF admissions).

However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

The Alliance notifies the identified responsible care manager of the assignment and of the member's admission status, including the location of admission, and ensure that the discharging facility has the name and contact information, including phone number, of the identified care manager in the discharge planning document. The member must be given the care manager's contact information as part of the discharge planning document, as described below.

Care Manager Responsibilities

The care manager responsible for TCS is responsible for coordinating and verifying that members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. Hospital and

nursing home staff who help with discharge plans should work with, but do not supplant the need for, a care manager unless the responsibility for TCS is fully contracted out.
The care manager is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the care manager does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services and follow-ups, noted below. Based on the phased implementation timeline, the care manager is responsible for completing all required responsibilities outlined below for high-risk members starting on January 1, 2023, and for all members starting on January 1, 2024.

The Alliance and the assigned care managers ensure Member transitions to and from a SNF are timely and do not delay or interrupt any Medically Necessary services or care, and that all required transitional care activities are completed.

Discharge Risk Assessment and Discharge Planning
A core responsibility of the care manager is to coordinate with discharging facilities to ensure the care manager fully understands the potential needs and the needed follow-up plans for the member and to ensure the member participates in the care plan and receives and understands information about their needed care. To do this, the care manager must complete the following:

- Risk Assessment:
    - The care manager must assess the member's risk for adverse outcomes to inform needed TCS. This must include, reviewing information the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The care manager may supplement this risk assessment as needed through member engagement. During this process the care manager must also identify members who may be newly eligible for ongoing care management (ECM/CCM) and/or Community Supports and make appropriate referrals.
    -
- Discharge Instructions:
    - Care managers must receive and review a copy of the discharging facility's discharge instructions given to the member, including medication reconciliation completed upon discharge by the discharging facility.
    - After discharge, upon member engagement, care manager must review the discharge instructions with the member and ensure that member can have any questions answered.
    - A best practice (not required) is for the care manager to work with the facility to ensure that the care manager's name and contact information are integrated into the discharge documents.
- Discharge Summary and Clinical Information Sharing:
    - Care managers must receive and review a copy of the discharging facility's discharge summary once it is complete.
    - Care managers must ensure all follow-up providers have access to the needed clinical information from the discharging facility, including the discharge summary.

Necessary Post-Discharge Services and Follow-Ups

Knowing that immediately post-discharge is an especially vulnerable time for high-risk members, support and follow-up post-discharge are critical aspects for the care manager responsible for TCS, including tasks in the Alliance contract and as described below:

- Member Outreach:
    - The identified care manager is responsible for contacting the member within 7 days of discharge (may be sooner) and supporting the member in all needed TCS care identified at discharge, as well as any new needs identified through engagement with the member or their care providers.
- Ensuring needed post-discharge services are provided and follow-ups are completed, including (but not limited to) by assisting with making follow up provider appointments, to occur within 7 days post-discharge; connecting to the PCP (if different); and arranging transportation.
- SUD and mental health treatment initiation or continuation for those who have an identified SUD or Mental health condition.
- Medication reconciliation, post discharge:
- Care manager must ensure this is complete after individual is discharged. This can be done by the follow-up provider, such as the PCP, or by the care manager if they hold an appropriate license, or by another team member on the care manager's team that has appropriate license, in a manner that is consistent with California's licensing and scope of practice requirements, as well as applicable federal and state regulations.
- Completion of referrals to social service organizations, and referrals to necessary at-home services (DME, home health, etc.).
- Connection to community supports as needed.
- For members who are transferred to/from nursing facilities, ensure completion of care coordination tasks in the contract including:
    - Ensure outpatient appointments are scheduled prior to discharge;
    - Verify that Members arrive safely and have their medical needs met;
    - Follow-up with Members to ensure all TCS needs and requirements have been met.

End of TCS

TCS for high-risk members extends until the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document. TCS for high-risk members should always extend at least 30 days post-discharge. If the MCP has delegated TCS, the MCP must ensure that the delegate follows and coordinates services for the member until all aforementioned activities are completed. For those who have ongoing unmet needs, eligibility for ECM or CCM and/or Community Supports should be reconsidered.

For members who may not respond to the MCP's outreach attempts or did not attend scheduled follow-up ambulatory visits, the MCP must make reasonable effort to ensure members are engaged and that the follow-up ambulatory visits are completed. For example, the care manager must ensure the members know that TCS support is available for at least 30 days or use CHWs to conduct outreach and attempt to engage the members in person.

For members with multiple care transitions within a 30-day period, the MCP must ensure the same care manager is assigned to support them through all these transitions. If the second transition is within 7 days of the first transition, then the care manager must ensure the follow up visit is completed within 7-days post discharge after the last transition. The care manager

must also provide TCS support for at least 30 days after the last transition. These members should be considered for ECM/CCM and/or Community Supports eligibility.

Minimum TCS Elements and Processes for Lower-Risk Members

Lower-risk members in transition are defined as those not included in the high-risk definition above. The Alliance ensures that:

- The member has access to a specialized TCS team for a period of at least 30 days from the discharge: and
- Ambulatory follow-up occurs.

Dedicated Team/Phone Number for Member Contact and Support
The Alliance ensures that it has a dedicated team and phone number to support the transitioning members telephonically when they request help. The required features of this dedicated support service are as follows:

- Minimum Requirements for the Dedicated TCS Team:
    - First point of member contact may be a trained customer service representative or similar unlicensed team member. However, the team must consist of additional staff and support to provide an escalation pathway to allow the member to reach care management/clinical staff, who can address any of their issues that require licensed care providers. This may include nurse care managers or physicians.
    - The team is able to access discharge planning documents, if needed, to assist members with questions regarding care at the discharging facility, including medication changes.
    - The team must is to provide assistance for any TCS need, including (but not limited to) help with access to ambulatory care, appointment scheduling, referrals/handoffs to needed social services or community-based resources, including arranging NEMT.
    - The team must is to place and coordinate referrals to longer term care management programs (ECM/CCM) and/or Community Supports at any point during the transition.
- Minimum Requirements for the Phone Line:
    - The Alliance offers, at minimum, dedicated telephonic support services for members experiencing a transition of care. The Alliance leverages existing member support telephone services to meet this requirement. During business hours, the Alliance ensures that members are able to connect with a live team dedicated to TCS.
    - Outside of business hours, the Alliance ensures that:
        - Members are referred to emergency services if needed;
        - Members can leave a message;
        - Messages are shared with the dedicated TCS team. A TCS team staff responds to members within 1 business day after the initial phone call.
- Member Communication of TCS Support:
    - The Alliance ensures lower risk members in transition receive direct communication about the dedicated TCS team and phone line and how to access it. The Alliance makes best efforts to ensure members receive this information no later than 24 hours after plans are notified of the discharge.

Necessary Post-Discharge Services and Follow-Ups for Lower-Risk Members

In addition to the dedicated call line, the Alliance ensures that each lower-risk member in transition completes a follow-up ambulatory visit with a physician or advanced practice provider (with prescribing authority) within 30 days of discharge for necessary post-discharge care and services, such as medication reconciliation post-discharge, which is a critical TCS requirement. In addition, for any members who have open preventive services care gaps or have not had a PCP visit within 12 months, the Alliance ensures that each lower-risk member has PCP follow up in addition to any other non-PCP ambulatory visits that may be needed.

End of TCS for Lower-Risk Members
The Alliance continues to offer TCS support through a dedicated telephonic team for at least 30 days post-discharge. In addition to accepting referrals to longer term care management at any point during the transition, the Alliance uses data including any information from admission, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or Community Supports.

Guidance for Members Enrolled with Multiple Payors
Given that the Alliance is responsible for coordinating whole-person care, even for services or benefits carved-out of Medi-Cal managed care, the Alliance or its contracted care manager is responsible for ensuring transitional care coordination for its members as outlined above. This also applies in instances where the Alliance is not the primary source of coverage for the triggering service (e.g., hospitalization for a Medicare FFS dual-eligible member, or an inpatient psychiatric admission covered by a County MHP).
For all members enrolled with multiple payors undergoing any transition, the Alliance is informed when their members are admitted, discharged, or transferred; the Alliance notifies existing Medi-Cal care managers (ECM or CCM) of admissions, discharges, and transfers; and the Alliance conducts prior authorizations and coordinates, in a timely manner, for any Medi-Cal covered benefits where Medi-Cal is the primary payor. However, there are specific modifications to the assignment of a care manager and care manager responsibilities as follows:

- Requirements for Members Dual-Eligible for Medi-Cal and Medicare in Medicare Medi-Cal Plans or Dual-Eligible Special Needs Plans (D-SNPs):
    - For admissions, transfers and discharges involving dually eligible members enrolled in Medicare Medi-Cal Plans (MMPs), or members enrolled in any other D-SNP, the MMP/ D-SNP is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including services delivered via Medi-Cal Managed Care and Medi-Cal FFS. Thus, the Alliance is not responsible for assigning a transitional care manager or any transitional care manager responsibilities for dually eligible beneficiaries enrolled in MMPs or D-SNPs. However, if a member has an existing ECM or CCM care manager, the Alliance is responsible for notifying that care manager of the admission, discharge or transfer.
    - For admissions, transfers and discharges involving Alliance members dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA plans (except D-SNPs), the Alliance remains responsible for ensuring all transitional care requirements are complete, including assigning or delegating a care manager or having a dedicated TCS team/phone number.

- Requirements for When County MHPs or DMC-ODS Are the Primary Payors:
    - For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where the county MHP is the

primary payor, and for members who are admitted for residential SUD treatment, including residential withdrawal management, where DMC-ODS is the primary payor, MHPs or DMC-ODS are primarily responsible for coordination of care with the member upon discharge. However, MHPs and DMC-ODS have limited access/ability to coordinate across the Alliance or physical health care needs, therefore:

- In addition to the core Alliance responsibilities noted above, the Alliance assigns or contracts with a care manager to coordinate with behavioral health or county care coordinators, ensure physical health follow-up needs are met, and assess for additional care management needs or services such as CCM, ECM, or Community Supports.
- The Alliance has MOUs with required entities, including Alameda County Behavioral Health Services, to facilitate care coordination and ensure non-duplication of services. In 2024,Alliance will be implementing the expanded MOU requirements to include additional entities, including local alcohol and SUD treatment services.

- Additional Requirements for Inpatient Medical Admission with Transfer to Inpatient Psychiatry or Residential Rehab:
  - For members who are admitted initially for a medical admission and transferred or discharged to a behavioral health facility, including a SUD psychiatric or a residential rehab facility (including intra-hospital transfers to a psychiatric-distinct unit of a hospital):
    - The Alliance is responsible for all TCS during the transfer/discharge to the behavioral health facility.
    - TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination. In these instances, this likely will be after the member arrives at the behavioral health facility, medication reconciliation has occurred, and all information sharing between institutions is complete.
    - After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, the Alliance follows the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

Scope

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

Referral Screening

1. CM staff will:
   a. Receive referrals from:
      i. Admission, Discharge, and Transfer (ADT) reports,

ii. Inpatient Utilization Management and other departments
iii. Phone, fax or email

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. 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 within 24 – 72 hours (1 business day).

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.

Triage and Assignment of TCS case

1. CM staff assignments will be made based on workload, discipline and risk stratification of case.
2. Assignment will be made within 24 hours of admission transfer or discharge when an ADT feed is available, or within 24 hours of the Alliance notification of any planned admissions, or of any admissions, discharges or transfers for instances where no ADT feed exists.
3. The notification timeframe will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.
4. For members enrolled in CCM or ECM, the Alliance will ensure that the member's assigned ECM Lead Care Manager or CCM care manager is the care manager who will provide all TCS.

Outreach

1. The assigned care manager will ensure the discharging facility has the name and contact information, including the phone number of the assigned care manager in the discharge planning document.

2. The assigned care manager will ensure the member is given the care manager's contact information as part of the discharge planning document.
3. The assigned care manager will send a letter to the member and the member's PCP to inform them of the member's facility admission and inform them of the care manager's contact information.

Care Manager Responsibilities

1. Discharge Risk Assessment
    a. The assigned care manager will ensure that the discharge risk assessment is complete.
    b. Will be completed prior to discharge to assess a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental condition, and/or SUD relapse.
    c. The assigned care manager will ensure the member is assessed to determine if they are newly eligible for ongoing care management services, such as ECM or CCM.

2. Discharge Planning Document
    a. The assigned care manager will ensure that the discharge planning document is complete, accurately coordinated, shared with appropriate parties and that the member does not receive two different discharge documents from discharging facility and from the care manager.
    b. The Assigned care manager must ensure that this document is shared with the member, member's parents or authorized representatives, and the treating providers, including the PCP, the discharging facility, and the receiving facility or provider.
    c. The discharge planning document shall use language that is culturally, linguistically, and literacy-level appropriate, and will include:
        i. preadmission status, predischarge support needs, discharge location, barriers to post-discharge plans, and information regarding available care and resources after discharge.
    d. The discharge planning document will also include the care manager's name and contact information and a description of TCS.

3. Necessary Post-Discharge Service and Follow-Ups
    a. Assigned care managers will ensure needed post-discharge services are provided, and follow-ups scheduled, including but not limited to follow-up provider appointments, SUD and mental health treatment initiation, medication reconciliation, referrals to social service organizations, and referrals to necessary services.
    b. Members will be offered the direct assistance of the care manager, but members may choose to have limited to no contact with the care manager. In these cases, at a minimum, the care manager will act as a liaison coordinating care among the discharging facility, the PCP and the Alliance.

End of TCS

a. TCS will end once the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document.

b. For delegation, the Alliance will ensure the delegate follows and coordinates services for the members until all activities are completed.
c. For members who have ongoing unmet needs, eligibility for ECM or CCM will be reconsidered.

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 TCS cases opened initially as transitional care, 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 in accordance with CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment.

   A CCM Referral Form is at Attachment 1. However, a referral form is not necessary, and all information can be taken by phone or by any other means.
3. 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*.

DEFINITIONS

None

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Members
Alliance Delegated Groups
Alliance Directly Contracted Physicians

RELATED POLICIES AND PROCEDURES AND OTHER DOCUMENTS

CM-001 CCM Identification Screening Enrollment and Assessment
CM Referral Form

REVISION HISTORY

02/21/2023, 9/19/2023, **8/21/2024**

***Red = Substantive Updates**
Black = Annual Review

REFERENCES

1. Population Health Management (PHM) Policy Guide
2. CM-001, Policy and Procedure, Complex Case Management Identification, Screening, Enrollment and Assessment

MONITORING

Policy is reviewed at a minimum annually.

POLICY AND PROCEDURE

Policy Number	CM-035
Policy Name	Prescreening Process – ECM and CS Providers
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Health Care Services~~Senior Director, Health Care Services~~
Lines of Business	MCAL
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD~~5/15/2024~~
Administrative Oversight Committee Approval Date	TBD~~6/12/2024~~

POLICY STATEMENT

1.1. In order to provide Community Supports (CS) services or Enhanced Care Management (ECM) to eligible Alameda Alliance for Health (AAH) Medi-Cal members, AAH contracts with a network of Providers.

1.2. AAH ensures that Providers comply with program requirements as outlined in the Department of Healthcare Services (DHCS) Contract, Policy Guides, and All-Plan Letters (APLs).

1.3. Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

~~1.1. In order to provide Community Supports (CS) services or Enhanced Care Management (ECM) to eligible Alameda Alliance for Health (AAH) Medi-Cal members, AAH contracts with a network of Providers.~~

~~1.2. AAH ensures that Providers comply with program requirements as outlined in CalAIM Program.~~

~~1.3. Delegated Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.~~

PROCEDURE

2.1 External Entity Interested in Contracting with AAH

2.1.1 An External Entity contacts the Alliance to show interest in becoming a contracted ECM/CS provider

2.1.1.1 The Alliance sends the External Entity an Entity Interest Packet that consists of:

- ECM/CS Entity Interest Form
- ECM/CS Provider Certification Application

2.1.1.2 The External Entity is provided with instructions on how to complete and submit the Entity Interest Packet (including all supporting documentation) to the Alliance Provider Services team.

2.1.1.3 The Alliance Provider Services team receives the completed Entity Interest Packet and logs it in the ECM/CS Entity Interest Tracker.

2.1.1.4 The Provider Services team sends the External Entity an acknowledgement letter within 5 business days of receipt of the packet.

2.1.1.5 The Provider Services team notifies the Alliance's ECM/CS Prescreening Panel when new Entity Interest Packets are available for review.

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~~**2.1 Interest in Contracting**~~

~~2.1.1 An external entity contacts the Alliance to show interest in becoming a CS or ECM provider~~

~~2.1.1.1 Interested entity is required to complete an Entity Interest Form and follow instructions as indicated on the Instructions tab~~

~~2.1.1.2 The Alliance receives the Entity Interest Form~~

~~2.1.1.3 Logs the Entity Interest Form into the ECM/CS Entity Interest Form Tracker~~

~~2.1.1.4 Notifies the appropriate Alliance leadership (of ECM or CS) of the new Entity Interest Form receipt~~

~~2.1.1.5 Alliance leadership reviews the entity interest form and documents acknowledgement decision in the ECM/CS Entity Interest Form Tracker~~

~~2.1.1.6 Interested Entity receives a letter confirming receipt of Entity Interest Form and possible next steps~~

2.2 ECM/CS Prescreening Process

2.2.1 Potential ECM/CS Providers are prescreened by the Alliance's ECM/CS Prescreening Panel. Depending on the needs of Alliance members at the time of submission, entities with complete submission packets may be invited to a "Provider Showcase" meeting with the Prescreening Panel within 90 calendar days of submission.

2.2.2 The ECM/CS Prescreening Panel consists of at least 1 representative from each of the following teams, but not limited to:

2.2.2.1 Health Care Services (HCS)

- Medical Director, Case Management
- Medical Director, Long Term Supportive Services
- Senior Director, Health Care Services
- Director of Social Determinants of Health
- Director of Long-Term Services & Supports
- Manager, ECM
- Manager, CS

2.2.2.2 Housing and Community Services Department (HCSD)

- Executive Director, Operations
- Director of Housing & Community Services
- Housing Program Manager

2.2.3 All representatives on the Panel evaluate potential ECM/CS Providers by reviewing their Entity Interest Packet and completing a Provider Scorecard (see attachments).

2.2.4 The ECM/CS Prescreening Panel meets at least quarterly to review preliminary scorecard results and decide which providers to invite for a "Provider Showcase" meeting.

2.2.4.1 The Provider Showcase meeting gives potential providers an opportunity to introduce their program to the Panel and for the Panel to ask the provider any outstanding questions about their ECM/CS program.

2.2.5 After the Provider Showcase meeting, the Panel finalizes Provider Scorecard results and prepares final recommendations for Senior Leadership approval.

2.2.6 ECM/CS providers who are approved by Senior Leadership are notified via email of the Alliance's decision to move forward with the Onboarding Process.

2.2.6.1 Approved providers will be notified within 120 calendar days of submission.

2.2.6.2 Senior Leadership approval of the Prescreening Panel's recommended provider does not guarantee a contract with the Alliance. Only entities who satisfy all Onboarding Requirements will be considered for a contract.

2.2.7 Submissions from external entities who were not selected for Onboarding will be retained. These entities will be subject to the same Prescreening Process should future network expansion needs arise.

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~~**2.2** Network Expansion~~

~~2.2.1 ECM/CS leadership determines network expansion is necessary~~

~~2.2.2 ECM/CS leadership reviews ECM/CS Entity Interest Form Tracker~~

~~2.2.2.1 The ECM/CS Entity Interest Form Tracker is filtered to appropriate Populations of Focus (PoF) or Community Supports (CS) service~~

~~2.2.3 ECM/CS leadership utilizes Provider Prescreening Scorecard to list all interested providers~~

~~2.2.3.1 Scorecard elements include:~~

- ~~Currently serving the community~~
- ~~Ability to bill for MediCal~~
- ~~Volume of members able to manage~~
- ~~Current program evaluation~~
- ~~Alignment with CS/ECM~~
- ~~Ability to obtain outcome data~~
- ~~Ease of AAH to operationalize~~

~~2.2.3.2 Committee of ECM/CS leaders is assembled, which can include, but is not limited to:~~

- ~~Medical Director of Case Management~~
- ~~Director of Social Determinants of Health~~
- ~~Manager of ECM~~
- ~~Supervisor of CS~~

~~2.2.3.3 The Committee each receives a copy of the Scorecard to further investigate each provider listed~~

~~2.2.3.4 Further investigation includes:~~

- ~~Reviewing provider's website or performing an internet search of the provider~~
- ~~Reviewing the submitted Entity Interest Form(s)~~
- ~~Document volume/capacity provider can manage~~

~~2.2.3.5 Once scorecards are complete, committee meets to discuss and prepare recommendations for internal organizational approval~~

~~2.2.3.6 Committee presents recommendation for organizational approval to move forward~~

2.3 Onboarding Process and Requirements

2.3.1 Kick-Off Meeting

2.3.1.1 The HCS team arranges recorded Kick-Off Meetings with all

ECM/CS providers who are selected for Onboarding.

2.3.1.2 The HCS team also invites the following Alliance departments to the Kick-Off Meetings:

- Housing and Community Services
- Provider Services
- Contracting
- Credentialing
- Finance
- Analytics
- IT/EDI

2.3.1.3 During the recorded Kick-Off Meeting, providers are given:

- Overview of Onboarding Process and Requirements (including milestones & timelines to go-live date)
- New Provider Forms (including forms required for HCS, Provider Services, Credentialing, Billing/Finance, EDI, and Analytics)
- Alliance's Contact List for support during Onboarding

2.3.1.4 After the Kick-Off, regular "check-in" meetings are scheduled with providers until successful go-live. The frequency of check-in meetings is mutually agreed upon by AAH and the ECM/CS provider.

2.3.2 The following departments are responsible for ensuring each element of the Onboarding Process are successfully executed with the ECM/CS Provider:

2.3.2.1 Health Care Services/Housing & Community Services

- Support ECM/CS Provider's clinical operational readiness, using the Provider Certification form to guide any areas in which the ECM/CS provider needs support to be in compliance with DHCS expectations
- ECM/CS Clinical Process Training (including referrals, authorizations, oversight/reporting, care coordination, interdisciplinary rounds)
- Convene ECM/CS provider and appropriate Alliance departments, as needed, to ensure progress towards go-live date
- Monitor and track onboarding milestones, and identify any risks that would compromise implementation
- Ensure any necessary DHCS submissions are completed in time for go-live (ie: Model of Care updates, Provider Capacity report)

2.3.2.2 Provider Services, Contracting & Credentialing

- Provider Roster
- Contract Development & Execution in partnership with HCS/HCSD Operations
- Provider Orientation/Training
- Provider Credentialing
- Provider Liaison activities, including payment/billing and contractual inquiries

2.3.2.3 IT/EDI, Claims, & Analytics

- Billing (including Claims & Encounters) Processes
- Return Transmission File (RTF) Process
- Member Information File (MIF) Process – *ECM only*
- Testing of data exchange with ECM/CS Providers

2.3.2.4 Finance

- Payment set-up

2.3.3 All contracted ECM/CS providers are supported after go-live, with ongoing operational and clinical meetings with the respective ECM/CS/HCSD teams.

~~**2.3** Movement Towards Contracting~~

~~2.3.1 From the approved recommended list, outreach is made to the interested providers to schedule a meeting~~

~~2.3.2 Meeting agenda includes:~~

~~2.3.2.1 Further discussion of Alliance's plan for expansion~~

~~2.3.2.2 Understanding the interested provider's process and program alignment with CS/ECM~~

~~2.3.2.3 If alignment is obtained, a project kick-off meeting will follow to discuss provider onboarding, provider certification, contracting and credentialling needs~~

~~2.3.3 Meeting participants may include, but not limited to:~~

~~2.3.3.1 CS/ECM leadership (Director, Medical Director, Manager/Supervisor)~~

~~2.3.3.2 Program Team representation~~

~~2.3.3.3 Contracting Team representation~~

~~**2.4** Provider Onboarding~~

~~2.4.1 Once it has been determined that the Alliance is interested in contracting with the interested provider, Provider Certification, Provider Contracting and Provider Credentialling needs to be completed~~

~~2.4.2 Provider Certification~~

~~2.4.2.1 Each provider is required to complete the Provider Certification which includes an in-depth look at the provider's current and future programming~~

~~2.4.2.2 The Alliance requests a variety of documents, that include (but are not limited to) an overview, programs, policies, procedures, workflows, and volume capacity to be submitted as evidence that the interested provider can meet the requirements of CS or ECM.~~

~~2.4.2.3 In the event that the Alliance determines contracting as a CS/ECM provider does not meet/match the requirements of the program, internal review and discussion occurs for~~

~~organizational approval to not proceed.~~

- ~~Communication is then provided back to the interested provider~~

~~2.4.3 Provider Contracting and Provider Credentialing~~

~~2.4.3.1 Provider contracting and provider credentialing is managed by Provider Services~~

DEFINITIONS

CS	Community Supports
AAH	Alameda Alliance for Health
ECM	Enhanced Care Management
HCSD	Housing and Community Services Department
~~CS~~	~~Community Supports~~
~~AAH~~	~~Alameda Alliance for Health~~
~~ECM~~	~~Enhanced Care Management~~

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Housing and Community Services Department
Provider Services
Contracting
Credentialing
Finance
Information Technology (EDI)
Claims
Analytics
~~Health Care Services~~
~~Analytics~~

RELATED POLICIES AND PROCEDURES

CRE-018 Credentialing and Recredentialing of Community Supports Providers

REVISION HISTORY

New Policy: 6/12/2024, **2/25/2025**
~~New Policy: 6/12/2024~~

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REFERENCES

DHCS Enhanced Care Management and Community Supports Resource Page
~~California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021~~

MONITORING

Quarterly monitoring of the providers' capacity is reviewed to determine whether further network expansion is needed to ensure adequate access to services for Alliance members ~~Quarterly monitoring of the providers' capacity is reviewed to see if further expansion is necessary~~