Quality Improvement Health Equity Utilization Management Committee Voting Items

Policies & Procedures
May 8, 2026

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

Policy Procedures Summary of Changes

Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update (X)	New Policy (X)	Annual Review or Formatting Changes (X)	Retire (X)	Presenter	Subcommittee Approval Date (QIHEC, PRCC, P&T) if applicable	LOB (MCAL, IHSS, and/or D-SNP)
CMDM	CM-004	CCM Identification Screening Enrollment and Assessment	Care Coordination of Services	addition of care coordination for cell gene therapy	X				Lily Hunter		MCAL/GC
CMDM	CM-005	Disease Management Programs	Disease management services provided at the Alliance for members	annual review; added D-SNP elements (including CICM); broadened prescreening panel participation			X		Lily Hunter		MCAL/GC
CMDM	CM-020	Health Information Form/Member Evaluation Tool (HIF/MET)	Purpose behind the HIF/MET completion and data collection and sharing	Formatting update	x				Lily Hunter		MCAL/GC
CMDM	CM-029	Developmental Disabilities	Referrals to Regional Center of the East Bay and working collaboratively to support shared members	annual review			X		Lily Hunter		MCAL/GC
QI	D-006	Quality Improvement Chronic Care Improvement Program	Describes the Chronic Care Improvement Program (CCIP) including requirements for identification, interventions, monitoring, and evlauating outcomes for chronic disease management	New policy outlining CCIP requirements and adherence to the Plan-Do-Study-Act model, submission to CMS and annual updates.		x			M.Stott		DSNP
UM	UM 051	Timeliness of UM Decision Making and Notifications	Describes the Alliance procceses for making deterinations timely	Updated verbiage per IA Recommendations r/t audits	x				M. Findlater		ALL LOB
UM	UM 056	Standing Referrals	Describes the Alliance Processes for Standing referrals	Updated verbiage per IA Recommendations r/t audits. Minor Grammar Updates	x				M. Findlater		All LOB
UM	UM 068	Tertiary and Quaternary Review Process	Describes the Alliance process for Authorizations to TQ Centers	Updated verbiage per IA Recommendations r/t audits. Minor Grammar Updates	x				M. Findlater		All LOB
UM	UM-D-005	Review of Admissions, Discharge and Transfer Files	Describes the review of the logs related to ADT for D-SNP	Updated verbiage per IA Recommendations r/t audits. Minor Grammar Updates	x				M. Findlater		D-SNP
UM	UM-D-009	Integrated Organization Determinations	Describes the review and process for D-SNP Org determinations	Updated verbiage per IA Recommendations r/t audits. Minor Grammar Updates	x				M. Findlater		D-SNP
UM	UM 052	Discharge planning to a lower level of care (including granting administrative days pending placement for facilities contracted for administrative days	Describes the IP UM department's policies and processes for Admin days for acute inpatient stays.	Updated language related to the TAR criteria for administrative days.	x				M. Findlater		All LOB
UM	UM-D-001	Prior Authorization, Concurrent Review, organization determination audit process	Describes the process for the internal departments to audit the UM components of the authorizations	Updated verbiage per IA Recommendations r/t audits. Minor Grammar Updates	x				M. Findlater		D-SNP
UM	UM- 029	Sensitive Services	Describes the processes to authorize sensitive services including STD testing, treatment, family planning, sterilization and fertility/ infertility treatments	Updated the policy to align with DMHC APL 25-021 for infertility/ fertility treatements for Group Care Members	x				M. Findlater		ALL LOB

POLICY AND PROCEDURE

Policy Number	CM-004
Policy Name	Care Coordination of Services
Department Name	Case and Disease Management Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal and Group Care
Effective Date	06/01/2012
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

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

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

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

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

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

PROCEDURE

Scope

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

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

Referral Screening

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

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

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

   ii. Routine – referral opened within ~~5~~ 14 calendar days.

If at any time, the Manager of CM or designee or referral source believes that the case is of an urgent nature, priority will be given to the case to be completed as soon as possible.

Case Manager Role in Care Coordination Case

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

   Provision of care coordination and BPHM includes but is not limited to:
   a. Ensuring that each member has an ongoing source of care that is appropriate, ongoing and timely to meet the member's needs;
   b. Ensuring members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;
   c. Ensuring that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with the CC Staff;
   d. Ensuring each Member receives all needed preventive services in partnership with the Member's assigned PCP and in partnership with the Plan's Quality department initiatives;
   e. Ensuring efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from Out-of-Network Providers;
   f. Facilitating access to care for Members by helping to make appointments, arranging transportation;

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

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

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

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

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

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

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

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

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

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

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

r. Ensuring no duplication of services occur

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

safety. The assistance that the CC staff provides towards a CCM case is generally of a short-term nature and is directed as specified in the Plan of Care.

4. The CC staff shall arrange these services and document such within the Clinical Information System.
5. CC staff may also assist CM staff with care coordination needs. Referrals are made from the CM process to the following:
    a. Behavioral Health Clinician. Referrals shall be made to the Behavioral Health Clinician for behavioral health CM services for Medi-Cal members with low to moderate risk members and Alameda County program for moderate to high-risk members. Case conferences shall be arranged as necessary for those with co-morbid mental and physical health conditions. The Alliance will provide care coordination services for any medical care and services in collaboration with the Behavioral Health Clinician.
        i. For members without significant medical/surgical issues, the members will be managed by the Behavior Health Clinician.
    b. Utilization Management (UM). Prior authorization functions are handled by the UM department. All requests for authorizations shall be directed to the UM department following standard procedures.
    c. Community Resources. The CM staff can arrange directly for services via known community resources or request assistance from the Health Navigator in doing so. The Alliance has a list of community resources available to assist the CMs and others in providing community services.
    d. Other services or providers as appropriate to the member's Plan of Care.
6. All referrals from CM staff require follow-up unless specified as an optional recommendation by the CM staff. The CM staff will document the schedule for follow-up within the system of record. The follow up due date will not exceed 30 calendar days.

Referral Processing Timeframes

1. The CC designee processes referral requests within one working day from receipt of the request for care coordination services.
2. Recipients of the CC referral shall open the referral according to the case priority classification:
    a. Urgent – referral opened and started within 1-3 working days
    b. Routine – referral opened and started within ~~5~~ 14 calendar days
    c. Unknown at time of referral.
3. Follow-up to referrals will be made as specified by the referral need, but no later than 30 calendar days after the referral is made.

Children with Special Health Care Needs (CSHCN)

1. For Children with Special Health Care Needs (CSHCN) receive a comprehensive assessment of health related needs.
2. Once the assessment is complete, the CM staff will assist with ensuring and monitoring timely access (including but not limited) to:
    a. Pediatric specialists
    b. Sub-specialists
    c. Ancillary therapists
    d. Transportation
    e. DME and supplies

These may include assignment to a specialist as a PCP, standing referrals or other methods.

3. As appropriate, members will be assessed for California's Children Services (CCS) and Developmental Disabilities (DD) and referrals will be made as needed.

Direct Observed Therapy for TB

1. The Plan has an MOU in place with the LHD to ensure joint case management and care coordination for members with active TB.

2. Members with active TB and members who have treatment resistance or non-compliance issues will be referred to the TB control office of the LHD for DOT.

3. CM staff will collaborate/joint case manage with the LHD TB Control Officer.

Coordination with IHSS

AAH maintains procedures for identifying and referring eligible Members to the county IHSS program. AAH's procedures address the following requirements:

1. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;

2. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies AAH that IHSS is no longer needed for the Member;

3. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;

4. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements

5. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.

6. To facilitate coordination, AAH has MOUs with each county IHSS agency within AAH's Service Area in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*). The MOU delineates the roles and responsibilities of AAH and IHSS in providing IHSS to the Members.

7. Regular communication with IHSS regarding member status for open medical issues and related social issues.

Cell and Gene Therapy (CGT)

7.1. The Alliance Case Management department provides care coordination and assistance to members in accessing one of the two CGT sickle cell disease medications, including making and assisting with referrals as appropriate. The Alliance remains responsible for all associate outpatient or inpatient medical services and non-medical ancillary services that support members through their CGT treatments including pre/post-treatment services, and administration associated fees and supplies. The Alliance assists CGT recipients in accessing timely Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services and in accessing prepayment or reimbursement for travel expenses related to CGT for members and their caregivers, as applicable.

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Referrals to CCM

1. CCM referrals may originate from any source including, but not limited to, self-referral, caregiver, Primary Care Providers or Specialists, discharge planners at medical facilities, health information line referrals, and internal department referrals such as UM, Disease Management and Member Services.
2. For CC cases opened initially as care coordination, but after the initial or subsequent CM staff interventions is found to be of a higher risk, the CM staff will contact the Department Management or CCM staff to discuss case needs.
3. Referrals that are selected for CCM are not diagnosis-specific, but rather based on the following general criteria:
    a. The degree and complexity of the member's illness is typically severe.
    b. The level of management necessary is typically intensive.
    c. The amount of resources required for the member to regain optimal health or improved functionality is typically extensive.
4. If case is to be referred for CCM, information needed for a CCM referral includes:
    a. Referral or data source

b. Date referral received by Intake. If secondary referral, document initial contact information and date.

c. Member information

d. Reason for referral

e. Additional information, as necessary.

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

5. Upon receipt of the necessary information for a referral, the CM/DM designated staff shall document the referral in the member's file by entering the information into the referral summary screen in the Clinical Information System. Details on data entry are described in *CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment*.

1. **Referrals from CCM to CC**

During the CCM Assessment and Triage phase or before a case is opened to CCM, the Manager of CM/DM or the assigned CM staff may refer the case to a Health Navigator instead of a CM if the case is determined to be of low complexity and member's medical history is of low risk. The assigned CM staff will access the appropriate section on the General Assessment and record the referral decision and create a task as outlined in *CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening Enrollment and Assessment.*

DEFINITIONS

Children with Special Health Care Needs: members who are or at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type or amount beyond that generally required by children.

Referral: The arrangement for services by another care provider or entity.

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Attachment 1. Referral Form
Complex Case Management (CCM) Program Description
CM-001 Policy and Procedure, CCM Identification Screening Enrollment and Assessment
CM-002 Policy and Procedure, Complex Case Management (CCM) Plan Development and Management
CM-004 Policy and Procedure, Management (CCM) Plan Evaluation and Closure

REVISION HISTORY

12/05/2012, 03/01/2016, 03/21/2019, 04/16/2019, 05/21/2020, 05/21/2021, 9/16/2021, 3/22/2022, 1/11/2023, 9/19/2023, 12/19/2023, 9/18/2024, 9/17/2025

REFERENCES

1. NCQA QI 5 Element C
2. CCM Referral
3. CM-001, Policy and Procedure, Complex Case Management Identification, Screening, Enrollment and Assessment
4. CM-002 Policy and Procedure, Complex Case Management (CCM) Plan Development and Management

MONITORING

Please refer to *CM-006 – Internal Audit and Monitoring*, for details on productivity monitoring and quality auditing of CCM cases, including identification and assessment timeframes.

ATTACHMENT 1

Case and Disease Management (CMDM) – Program Referral Form

The Alameda Alliance for Health (Alliance) Case and Disease Management (CMDM) Program Referral Form is confidential. Filling out this form will help us better serve our members.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Please mail, send by a secure email*, or fax the completed form to:
   Alameda Alliance for Health
   ATTN: Case and Disease Management Department (CMDM)
   1240 South Loop Road, Alameda, CA 94502
   Secure Email*: **deptcmdm@alamedaalliance.org**
   Fax: **1.510.747.4130**
   If you have questions about how to send a secure email, please visit **www.alamedaalliance.org*

For questions, please contact the Alliance CMDM Department via email or call toll-free at **1.877.251.9612.**

PLEASE NOTE: The Alliance will directly notify the member which CMDM program can provide them with services.

REQUEST DATE (MM/DD/YYYY): ____________

SECTION 1: REFERRING PROVIDER INFORMATION

Name: ____________

Facility/Clinic Name: ____________

Phone Number: ____________ Fax Number: ____________

Referral Source: ☐ Community Partner ☐ Hospital ☐ PCP ☐ Specialty Provider

☐ Other: ____________

SECTION 2: MEMBER INFORMATION

Last Name: ____________ First Name: ____________

Alliance Member ID #: ____________ Date of Birth (MM/DD/YYYY): ____________

Phone Number: ____________ Sex: ☐ Female ☐ Male

Address *(or location, i.e., under 5th St. bridge)*: ____________

City: ____________ State: ____________ Zip: ____________

SECTION 3: PROGRAM REFERRAL

Please select one (1) program per referral form:

☐ Case Management *(including Complex Case Management (CCM), Care Coordination, and Transitional Care Services (TCS))*

☐ Asthma Disease Management ☐ Depression Disease Management

☐ Cardiovascular Disease Management ☐ Diabetes Disease Management

☐ Other *(please provide details in Section 4)*

SECTION 4: REASON FOR REFERRAL

Situation/background *(including past medical history (PMH), if applicable, and attach supporting documents within the past 30 days)*:

This fax (and any attachments) is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, please contact the sender by telephone or fax and destroy all copies of the original message (and any attachments).

For all other member requests, please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm, at **1.510.747.4567.**

CMDM_PRVDR_FORMS_PROG REF 09/2023

POLICY AND PROCEDURE

Policy Number	CM-005
Policy Name	Disease Management
Department Name	Case and Disease Management Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	MCAL, IHSS
Effective Date	06/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	8/16/2024
Administrative Oversight Committee Approval Date	~~9/18/2024~~TBD

POLICY STATEMENT

Disease Management (DM) services at Alameda Alliance for Health (the Alliance) are provided to all Alliance members with a diagnosis of diabetes, asthma, hypertension or perinatal depression that meet certain criteria. The Alliance will:

- Provide disease management as an "opt-out" service meaning that all eligible members identified are enrolled unless they choose to decline participation or "opt-in" meaning that eligible members are not enrolled until they chose to receive Alliance disease management services.
- Ensure that all Alliance members are identified and stratified into appropriate levels for disease management services depending on risk.
- Provide DM services based on evidence-based guidelines and an individual assessment of gaps in care.
- Maintain documentation of program enrollment and provision of services using a Clinical Information System
- Promote DM to members and practitioners via written information about the program.

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

PROCEDURE

Scope

This Policy and Procedure addresses the DM process at the Alliance. DM consists of the following related processes: Identification and Screening; Risk Stratification; Enrollment; Assessment; Care Plan Development and Management; and DM Evaluation and Closure. Referrals to DM are also addressed as part of the Identification process. Definitions of terms used for the DM program are also included within this Policy and Procedure.

This policy does not address in detail the DM Assessment process or the DM Care Plan Development and Management process as the procedures outlined in CM - 001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment and CM - 002 Policy and Procedure, Complex Case Management (CCM) Plan Development and Management apply. Any changes from these referenced policies are addressed within this DM policy.

DM Identification and Screening

Members are eligible for DM if they have a diagnosis of diabetes, asthma, hypertension or are at risk for perinatal depression.

The Alliance informs practitioners about the DM programs through multiple methods, including but not limited to, Provider Services educational material, Alliance webpage, and Provider bulletins. The communication methods describe who is eligible for DM programs and how to refer members to DM services.

Training and/or targeted communications for key referral sources such as the CM department, UM department, Member Services, Hospital Discharge planners will occur at least annually.

1. Members are identified for program eligibility through one of the following:
    a. Monthly report from HealthCare Analytics department utilizing claims, encounter, and pharmacy data. The report is further risk stratified into low, moderate, or high risk.
    b. Health Risk Assessment (HRA) for Medi-Cal Seniors and Persons with Disability (SPD). Members are identified as eligible with the appropriate age and diagnoses eligible for the DM program, and have a score, as outlined in the CM-008 SPD HRA Survey and Interventions policy, calculated from HRA answers that may impact the member's health. The list of members

meeting these criteria will be provided to the CMDM Department for further processing.

Additional sources or reports from a source include, but are not limited to: self- referral, caregiver, Primary Care Providers or Specialists, discharge planners at medical facilities and internal department referrals such as Utilization Management, (UM), Case and Disease Management, Health Education, and Member Services. All referrals to DM should be directed to the CM/DM Department. A Referral Form is included in Attachment 1. However, a referral form is not required, and all information can be taken by phone or any other means.

Information needed for a DM referral includes:

i. Referral or data source (name, affiliation, and contact information).
ii. Date referral received. If secondary referral, document initial contact information and date.
iii. Member information
iv. Reason for referral
v. Diagnosis (asthma, diabetes, hypertension, or perinatal depression)
vi. Level of urgency
vii. Additional information as necessary.

2. Laboratory results, claims, and encounter data are used to identify members eligible for the DM program.

3. At risk eligible members (or parents/guardians of minors) are sent letters about the availability of the DM program services. The letter will also inform them how to use the program, eligibility criteria and opt-in and opt out program aspects.

4. Upon receipt of the necessary information for a referral, the CM/DM designee shall document the referral into the Clinical Information System. Members assigned to a delegate entity that provides Disease Management will be referred to the delegate.

5. If the member is no longer eligible for services, the case should be closed and the reason for case closure will be marked as termination of coverage.

DM Risk Stratification

1. All members who are directly referred to the Alliance DM services are stratified into the appropriate DM program.

2. Data reports provided to the Case & Disease Management Department monthly are already stratified into levels according to the following risk criteria:

   a. High Risk Diabetes: Eligible age members with a diagnosis of diabetes whose A1c is over 9.0, and has increased health services utilization over the past 12

months

b. Moderate Risk Diabetes: Eligible age members with a diagnosis of diabetes and identified gaps in diabetes such as no record of A1c, annual foot care appointment, eye exam, etc., or whose documented A1c is 8.0 to 9.0..

c. Low risk Diabetes: Eligible age members with a diagnosis of diabetes and who do not fall into the high or moderate risk category. These members may be new to the plan, have a new diagnosis of diabetes or have no identified gaps.

d. High Risk Asthma: Eligible age members with a diagnosis of asthma that have an increase in ER, hospital, or urgent care or clinic utilization, over-utilization of asthma medications or a score of <20 on an Asthma Control Test.

e. Low Risk Asthma: Eligible age members with a diagnosis of asthma who do not fall into the high-risk category.

f. High Risk Hypertension: Eligible age members with a diagnosis of hypertension whose blood pressure is not controlled and have at least one anti-hypertensive prescription medication or have increased health services utilization over the past 12 months.

g. Low Risk Hypertension: Eligible age members with a diagnosis of hypertension, and whose blood pressure was not controlled or have at least one anti-hypertension prescription medication and who do not fall into the high-risk category.

h. At Risk Perinatal Depression: Eligible age members identified as being pregnant or were pregnant within the past 12 months.

Formatted: Font: 12 pt

Formatted: Normal

Formatted: Font: 11.5 pt

3. Existing Complex Case Management (CCM) or Enhanced Care Management (ECM) cases will take precedence over the DM program for members that are eligible for multiple programs. The CM will determine the appropriateness of referring the member to the DM program or simply expand the existing CCM of ECM Care Plan.

4. The CM/DM designee will process referrals within the following time frames:
   a. Urgent – referral opened within 1 business day.
   b. Routine – referral opened within 5 business days.

5. DM referrals will be completed within the month of receipt of the request of the DM Identification and Stratification. If at any time, the CM or the referral source believes that the case is of an urgent nature, priority will be given to the case to be completed as soon as possible.

Enrollment

1. The Alliance will inform members of enrollment in the Alliance DM programs through the following methods:
   a. Asthma, Diabetes, and Hypertension ~~or Perinatal Depression~~ DM eligible members will receive a letter informing them of their enrollment.
   b. Members at-risk for perinatal depression will receive a letter informing them of DM services offered and how they may enroll.
2. Enrollment communications will explain to the member:
   a. How they became eligible for the program
   b. How to use the program services
   c. How to opt in or opt out of the program
3. Program engagement:
   a. Members will be considered enrolled and engaged when they do one of the following:
      i. Receive a letter and either call the DM program asking to learn more and agree to engage or return the Health Education Wellness form requesting program and education information.

Commented [LA1]: Don't we have an expanded engagement definition? Received a letter or requested DM services and engaged in care management, health coaching or health education?

Risk Assessment

1. Members who chose to engage in the DM programs will be assessed using an appropriate assessment within the Clinical Information System. Procedures for conducting assessments are addressed in *CM-001, Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment*.
   ~~1.~~

Formatted: Left, Indent: Left: 0.58", No bullets or numbering

2. Supports will be assigned depending on their risk stratification, needs and interest.
   - Health Navigation
   - Health Education/Coaching
   - Social Work
   - Medication reconciliation/education – Pharmacy
   - Nurse Case Management
   - Behavioral health care management

3. All cases assessed are already enrolled in the DM program per previous steps outlined above. However, if during the assessment process, the member chooses to opt-out of the program, the CM or the Health Navigator shall close the case appropriately in the Clinical Information System.

4. If unable to contact the member, the member should also be closed within the Program Enrollment Summary and the reason listed as unable to establish or maintain contact with member.

DM Plan Development and Management

1. The procedures described in *CM-002, Complex Case Management (CCM) Plan Development and Management,* apply to the development of a DM Care Plan. As described in that policy, the steps in developing the Care Plan involve:
    a. Development of case management goals, including prioritized goals
    b. Identification of barriers to meet the goals and complying with the plans
    c. Development of schedules for follow-up and communication with members
    d. Development and communication of member self-management plans
    e. Assessment of progress against care plans and goals, and modifications as needed

2. Condition monitoring (self-monitoring and medical testing) and adherence to the applicable chronic disease treatment plan will be an important component of the DM Plan of Care and goals should be set accordingly.

3. The Care Plan for the DM Programs will contain goals. Goals will be set as short-term goals defined as achievable within 30 days. Goals can be extended by another 30 days, however, by the 90 day mark the member should have been reviewed at Case Rounds. At that time, the member may be referred to CCM or ECM for ongoing case management needs.

4. Members enrolled in Asthma Management DM Programs will be referred to the Alameda County Asthma Start and other Community Support providers for asthma case management and asthma remediation supports.

5. Referrals for additional services and resources will be made as documented in the Plan of Care. Referrals will be made as necessary and in a timely manner (within 7 business days of identifying the need) and follow up on these referrals will occur within 30 calendar days after the referral is made.

DM Case Evaluation and Closure

1. The DM program is structured where DM cases are closed either by meeting prescribed length in program criteria or by defined closure criteria.

2. High Risk Program enrollees will be evaluated for closure to DM services using *CM-003, Policy and Procedure, Complex Case Management Plan Evaluation and Closure.* CMs should aim to close the case within 6 months of enrollment, allowing for 30 days of conducting the assessment.

~~2.~~

DM Program enrollees will also be evaluated for closure to DM services using CM-003 *Policy and Procedure, Complex Case Management (CCM) Plan Evaluation and Closure*. However, the length of time in the program should not exceed 6 months of

Formatted: Font: 12 pt

Formatted: Normal, Left, No bullets or numbering

participation in the program. If the member is no longer identified as needing disease management supports, they will no longer be in the program.

Formatted: Font: 11.5 pt

Formatted: Normal, Right: 0.68", Tab stops: 0.65", Left

3. All closure actions will be documented in the Care Plan as applicable and in the Program Enrollment section of Clinical Information System.

4. At the time of case closure, a satisfaction survey and a case closure letter, if appropriate, will be sent.

DEFINITIONS

DM Identification: DM Identification is the initial process of identifying members who qualify for the DM program. DM identification is where members are identified from data sources and referrals are taken for members meeting defined criteria (age and diagnosis criteria).

DM Screening: DM Screening is the process where an initial non-clinical decision is made to determine whether a member remains administratively eligible to proceed to Risk Stratification. This process entails screening against eligibility status and whether the member is being managed in other programs.

DM Risk Stratification: Classification and placement of eligible members according to severity of condition based on data (claims, Rx, lab). The purpose is to place patients in categories of prioritization for a specific DM program or level of service. Stratification is a dynamic process and the member's DM program assignment may change with a change in their status.

DM Assessment Process: Assessment is a process of compiling data including claims and medication history, HRA data and member questions to provide the basis to analyze services needed and to assist in identifying care gaps or creating a care plan.

Care Gaps: Discrete services or tests that the member has not received that are recommended for the member based on approved clinical guidelines.

Care Plan: A comprehensive plan that includes a statement of problems/needs determined upon assessment, interventions to address the problems/needs, and measurable goals to demonstrate the resolution of problem/need, the time frame, the resources available and the desires/motivation of the member.

DM Intervention: An intervention is an action that increases the probability that a desired

outcome will occur.

Active Member Participation Rate: Number of members who have received at least one interactive contact in an intervention, divided by the number of members who are identified as eligible for the program.

Interactive contact: Two-way interaction in which the member receives self-management support or health education by interactive mail-based communication, phone, or online contact.

Opt in: A process in which eligible patients choose to receive disease management services and participate in a DM program. Also referred to as *active participation* or *voluntary participation*.

Opt out: A disease management program where eligible members elect not to receive services in order to decline participation in the DM program.

Disease Management: A multidisciplinary continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost- effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. It continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health (NCQA definition).

Outcomes: Measurable results of case management interventions, such as client knowledge, adherence, self-care, satisfaction, and attainment of a meaningful lifestyle.

Referrals: The arrangement for services by another care provider, agency, or entity.

AFFECTED DEPARTMENTS/PARTIES

All Alliance
Departments Alliance
Members Alliance
Delegated Groups
Alliance directly contracted physicians

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CM -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-003, Policy and Procedure, Complex Case Management Plan Evaluation and Closure DM Program Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment 1. DM Referral Action – Desk Reference

REVISION HISTORY

12/04/2012, 03/06/2016, 09/06/2018, 04/16/2019, 04/24/2020, 03/22/2022, 6/20/2023, **9/18/2024**

Red = substantive updates

REFERENCES

1. DHCS Contract Exhibit A, Attachment 11 Case Management and Care Coordination, Section 4 Disease Management Program.

MONITORING

The DM program is monitored through:

a. Identification and participation rates including active participation rates. At a minimum an annual evaluation is conducted of this measure and adjustments made to program participation rules as needed.
b. Audits and evaluation of cases using NCQA audit tools and other Alliance tools
c. Case rounds
d. Performance against DM timeliness standards
e. Member grievances specific to DM. Member grievances are reviewed as they are received for program interventions as well as annually in the aggregate for programmatic changes.
f. Satisfaction survey specific to the DM program. At a minimum, surveys are analyzed annually for improvements to the program design.
g. Clinical effectiveness measures as defined in the DM Program Description.

Case and Disease Management (CMDM) – Program Referral Form

The Alameda Alliance for Health (Alliance) Case and Disease Management (CMDM) Program Referral Form is confidential. Filling out this form will help us better serve our members.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Please mail, send by a secure email*, or fax the completed form to:
   Alameda Alliance for Health
   ATTN: Case and Disease Management Department (CMDM)
   1240 South Loop Road, Alameda, CA 94502
   Secure Email*: **deptcmdm@alamedaalliance.org**
   Fax: **1.510.747.4130**
   ***If you have questions about how to send a secure email, please visit www.alamedaalliance.org**

For questions, please contact the Alliance CMDM Department via email or call toll-free at **1.877.251.9612**.

PLEASE NOTE: The Alliance will directly notify the member which CMDM program can provide them with services.

REQUEST DATE (MM/DD/YYYY): ______

SECTION 1: REFERRING PROVIDER INFORMATION

Name: ______

Facility/Clinic Name: ______

Phone Number: ______ Fax Number: ______

Referral Source: ☐ Community Partner ☐ Hospital ☐ PCP ☐ Specialty Provider
☐ Other: ______

SECTION 2: MEMBER INFORMATION

Last Name: ______ First Name: ______

Alliance Member ID #: ______ Date of Birth (MM/DD/YYYY): ______

Phone Number: ______ Sex: ☐ Female ☐ Male

Address *(or location, i.e., under 5th St. bridge)*: ______

City: ______ State: ______ Zip: ______

SECTION 3: PROGRAM REFERRAL

Please select one (1) program per referral form:

☐ Case Management *(including Complex Case Management (CCM), Care Coordination, and Transitional Care Services (TCS))*

☐ Asthma Disease Management ☐ Depression Disease Management

☐ Cardiovascular Disease Management ☐ Diabetes Disease Management

☐ Other *(please provide details in Section 4)*

SECTION 4: REASON FOR REFERRAL

Situation/background *(including past medical history (PMH), if applicable, and attach supporting documents within the past 30 days)*:

This fax (and any attachments) is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, please contact the sender by telephone or fax and destroy all copies of the original message (and any attachments).

For all other member requests, please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm, at **1.510.747.4567**.

CMDM_PRVDR_FORMS_PROG REF 09/2023

h.

POLICY AND PROCEDURE

Policy Number	CM-020
Policy Name	Health Information Form/Member Evaluation Tool (HIF/MET)
Department Name	Case and Disease Management Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	12/17/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	8/24/2024
Administrative Oversight Committee Approval Date	~~9/18/2024~~TBD

POLICY STATEMENT

~~The~~ Alameda Alliance for Health (the Alliance) includes in the enrollment materials, a Health Information Form/Member Evaluation Tool (HIF/MET) for the member to complete and return. The Alliance uses the HIF/MET data to identify those members who are high risk and who may need expedited services, and/or may benefit from care coordination (including but not limited to, Children with Special Health Care Needs (CSHCN)).

PROCEDURE

The Health Information Form/Member Evaluation Tool (HIF/MET)

The Health Information Form/Member Evaluation Tool (HIF/MET) is a screening tool used by the Alliance to identify members with higher risk and more complex health care needs. Effective 1/01/2018, the Alliance mails the DHCS approved HIF/MET survey form to all new members through its welcome packet with a postage paid envelope for response. Newly enrolled members designated with a Seniors and Persons with Disabilities (SPD) code receive the Health Risk Assessment survey upon enrollment which includes the HIF/MET questions.

1. The Alliance will mail the HIF/MET form as a part of the New Member Packet to new Medi-Cal members identified through the DHCS eligibility files within two weeks of

enrollment into the plan. In instances where the member's eligibility changes from month to month, the member will be considered as a new member after a six (6) month gap in coverage and will be sent another HIF/MET form to complete.

2. Within 90 days of the new members' enrollment, the Alliance, through a vendor, makes at least two telephone call attempts with an IVR message to remind new members to return the HIF/MET form. This outreach can be completed with the member, the member's parents, or other authorized representatives.

3. Within 90 days of the new members' enrollment, the Alliance will conduct an initial screening of members' needs as identified in the HIF/MET completed form received within this period. Through this screening, members are sorted into high risk and low risk groups. Information and a copy of the HIF/MET form for members sorted into the high risk group are forwarded to the members' assigned PCP. PCPs are directed to further assess these members for expedited care.

Data Sharing

1. When necessary, the Alliance shares HIF/MET data with providers, subcontractors, and other sub-plan entities to facilitate care coordination for their members.

2. The Alliance will share HIF/MET data results with other Medi-Cal managed care plans upon request and after member is disenrolled with the Alliance.

DEFINITIONS / ACRONYMS

HIF/MET - Health Information Form/Member Evaluation Tool (HIF/MET)
Primary Care Physician (PCP)
Seniors and Persons with Disabilities (SPD)

Member Evaluation Tool (MET) means the information collected from a health information form (HIF), a high-level initial assessment completed by Members at the time of enrollment through which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. For newly enrolled SPD members, the Alliance uses the MET as part of the health risk assessment process.

AFFECTED DEPARTMENTS/PARTIES

Case and Disease Management

RELATED POLICIES AND PROCEDURES

CM-007 - SPD Health Risk Initial Stratification
CM-008 - SPD HRA – Survey and Interventions

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

DHCS Approved HIF/MET Survey Form

REVISION HISTORY

12/17/2015, 8/29/2016, 1/04/2017, 4/12/2018, 11/15/2018, 1/16/2020, 11/19/2020, 03/22/2022, 6/20/2023, 9/19/2023, 9/18/2024

REFERENCES

Title 42, Section 438.208
Alameda Alliance Provider Manual
DHCS All Plan Letter 17-013 HRA for SPD Members

MONITORING

This Policy will be reviewed annually to ensure compliance with regulatory and contractual requirements. On review of this P&P, codes will also be re-evaluated and validated.

POLICY AND PROCEDURE

Policy Number	CM-029
Policy Name	Developmental Disabilities
Department Name	Case and Disease Management Division
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	MCAL, IHSS
Effective Date	11/4/2005
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2024~~TBD
Administrative Oversight Committee Approval Date	~~9/18/2024~~TBD

POLICY STATEMENT

1) Alameda Alliance for Health (the Alliance):

a) Maintains a Memorandum of Understanding (MOU) with Regional Center of the East Bay (RCEB) for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of services for eligible members suspected of having developmental disabilities.

b) Collaborates with the Regional Center of the East Bay (RCEB) to establish mutually agreeable policies and procedures for problem resolution that include the following:

i) Appoints a liaison, as needed, to review and resolve complaints concerning conflicts between the Alliance and RCEB regarding program eligibility, diagnostic testing, plan of treatment, and associated benefits for the member's care;

ii) Refers unresolved problems to the Alliance's DHCS contract manager and to the State Department of Developmental Services or California Department of Education (CDE) office.

iii) Determination of medically necessary diagnostic and preventative services and treatment plans for members.

iv) Case management and care coordination to ensure the provision of all medically necessary covered services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

c) Implements and maintains systems to identify members with developmental disabilities that may meet requirements for participation in a Home and Community Based Services (HCBS) Waiver program and ensures that these members are referred to the appropriate HCBS Waiver program administered by the State Department of Developmental Services;

   i) AAH refers members with developmental disabilities to Regional Center of the East Bay (RCEB) for evaluation and access to non-medical services provided by RCEB, including, but not limited to, respite, out-of-home placement, and supportive living.

d) Continues to provide comprehensive case management services and cover all medically necessary services for the members who meet criteria and are placed in a HCBS Waiver program while remaining enrolled with the Alliance;

e) Continues to provide comprehensive case management services and cover all medically necessary services for the members who do not meet criteria for placement in a HCBS Waiver program while remaining enrolled with the Alliance;

2) Contracted PCPs and specialists (practitioners) are responsible for the identification and referral of members with developmental disabilities/behavioral health disorders outside their scope of practice as follows:

   a) Medi-Cal members referred to the Regional Center of the East Bay (RCEB). RCEB collaborates with the plan regarding Behavioral Health referrals and informs families how to reach out to the plan for referral to the designated Behavioral Health organization.

   b) Other line of business members referred to the designated Behavioral Health organization.

   c) Preventive care will be provided according to the most recent American Academy of Pediatrics (AAP) Guidelines for Children and the Guidelines of the United States Preventive Services Task Force (USPTF) for adults.

3) Members identified with or suspected of having developmental disabilities receive all medically necessary and appropriate developmental screening, primary preventive services, and diagnostic and treatment services.

4) The Alliance provides genetic counseling and other covered prenatal genetic testing services when medically indicated for Members at risk of parenting a child with a developmental disability.

5) Data files identifying plan members receiving RCEB services will be forwarded to the appropriate assigned PCPs and delegated medical groups.

PROCEDURE

Primary Care and Specialty Referrals

A. PCPs are required to provide all necessary primary care for individuals with developmental disabilities including:

   1. Well Child Exams;

   2. Immunizations;

3. Developmental status screening;
4. Illness or Injury Care;
5. Diagnostic testing (laboratory, x-rays) as needed;
6. Health Education as needed; and
7. Other primary care services as needed.

B. PCPs are required to arrange for and/or request from the Alliance all medically necessary specialty practitioner, diagnostic, or therapeutic services including:
   1. Referral to specialist or sub-specialist practitioners (e.g., neurologists, physiatrists);
   2. Referrals for occupational or physical therapy
   3. Orders for medically necessary durable medical equipment (DME) or home health services; and
   4. Referrals/authorizations for specialized diagnostic testing (e.g., CT or MRI).

C. Alliance Utilization Management (UM) staff arranges for all necessary specialty care for Members, including out-of-network referrals as needed due to the condition of the Member.

D. The Alliance covers prenatal genetic diagnostic testing for those Members whose PCPs or OB practitioners identify a need.

E. PCPs and Alliance UM are responsible for referral to RCEB for Members in need of non-medical, home, and community-based services such as:
   1. Family support;
   2. Day habilitation;
   3. Respite care; and/or
   4. Residential care or assisted living.

F. PCPs and Alliance UM are responsible for referral to Behavior Health organization for members in need of non-medical, home and community-based services such as:
   1. Training in skills for daily living;
   2. Acquisition of skills and behavior and/or;
      a. Exception: if a family requests American Disabilities Act (ADA) services, the family will be referred back to RCEB.

G. PCPs and Alliance UM are responsible for referrals of children (over 36 months of age) and adults suspected of having developmental disabilities to RCEB when requested by the Member, or his/her family if a minor.
   1. The Member's disability must originate before the 18th birthday, be expected to continue indefinitely, and constitute a substantial disability.
   2. A list of definitions and eligibility criteria can be found in the California Code of Regulations (CCR) Title 22 Sections 54000, 54001, 54002, and 54010.
   3. RCEB reviews referrals to determine RCEB eligibility and considers the need for developmental programs or family support services that are not available from other resources.

4. For referral procedures for children aged 0 to 36 months see Policy UM-021 Early Start.

H. Referrals to RCEB from the PCP or Alliance UM, should be directed to the RCEB's intake coordinator and include the following information:

1. The reason for referral;
2. The complete medical history and physical examination, including appropriate developmental screens;
3. The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated; and
4. The referral should be directed to:

   a. For children 3 years old and under:

   - Early Start Program

     Phone: 510-618-6195

     Fax: 510-678-4156

     Email: EarlyStartReferrals@rceb.org

   b. For children over 3 years old:

     Phone: 510-618-6122

     Fax: 510-678-4122

     Email: intakeoverthree@rceb.org

* RCEB Medical Consultants are available for consultations on appropriate medical tests necessary for obtaining a specific diagnosis.

I. Intake staff reviews the referral to the RCEB within 15 working days of receipt. Evaluations must be performed within 120 days following review of referral, or sooner if a delay in assessment would expose the Member to unnecessary risk to health and safety. RCEB notifies the Member and the Alliance (if the Alliance provides RCEB with a release of information form signed by the Member) within 120 days after the referral is made regarding the Member's eligibility and recommendations for services.

J. Alliance UM is responsible for approving medically necessary referrals.

K. Alliance CM is responsible for the following activities:

1. Providing care coordination services for Members regardless of whether or not they receive services from RCEB.
2. Assisting the PCP as needed with the referral to RCEB, including arranging for transfer of medical information, and contact with RCEB.
3. Coordinating necessary follow-up as needed between the PCP, specialty practitioners, and RCEB to assure an organized care plan and delivery for the Member.
4. Participating with RCEB staff, as indicated, in the development of the Individual Program Plan required for all persons with developmental disabilities to include identification of medical care services that need to be provided to the member.
5. Maintaining liaison with the Regional Center of the East Bay to:

   a. Assist members with developmental disabilities to understand and access services.

Commented [LK1]: Individual Program Plan

b. Act as a central point of contact for questions, access and care concerns, and problem resolution as required by Welfare and Institutions Code 14182 (c) (10).

L. See UM- 0017 Home and Community Based Services (Waiver) Programs for policy and procedures pertaining to HCBS.

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-019 *Delegation Oversight* for monitoring of delegation oversight.

Commented [HL2]: Old naming convention

Formatted: Indent: Left: 0.57", Right: 0.18", Space Before: 0 pt

DEFINITIONS

Home and Community Based Waiver Programs (HCBS) – Creative alternatives, allowed under federal law, eligible for Medi-Cal members. These services are to be implemented in the home or community for certain Medi-Cal beneficiaries to avoid hospitalization or nursing facility placement. Services provided under a waiver program are not typically part of the managed Medi-Cal plan benefit. These programs include, but are not limited to, the nursing facility/acute hospital (NF/AH) waiver.

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

Utilization Mgmt.
Member Services
Provider Services
Case Management

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

UM-008 Coordination of Care – California Children's Services (CCS)
UM-012 Coordination of Care-Behavioral Health
UM-017 Home and Community Based (Waiver) Services
UM-021 Early Start

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/20/2009, 6/9/2009, 4/1/2011, 6/1/2011, 8/30/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 3/22/2022, 6/28/2022, 6/20/2023, 9/19/2023, 9/185/2024

REFERENCES

1. MMCD APL 07-012 Identification of Regional Center Consumers.
2. MMCD Policy Letter 97-03 Services for Members with Developmental Disabilities
3. DHCS Contract Exhibit A, Attachment 11, Provision 10

MONITORING

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

POLICY AND PROCEDURE

Policy Number	QI-D-006
Policy Name	Quality Improvement Chronic Care Improvement Program
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Quality
Lines of Business	DSNP
Effective Date	01/01/2026
Subcommittee Name	Quality Improvement Health Equity/Utilization Management Committee
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

Alameda Alliance Wellness is committed to delivering high-quality, person-centered, and coordinated care to D-SNP members through the Chronic Care Improvement Program (CCIP). This program enhances chronic disease management, improves health outcomes, reduces health disparities, and ensures compliance with state and federal regulations. The program targets D-SNP members with multiple or sufficiently severe chronic conditions, such as diabetes, cardiovascular disease, chronic kidney disease, and dementia, using evidence-based interventions, continuous quality improvement, and interdisciplinary coordination.

The CCIP aligns with requirements by identifying eligible members, implementing interventions, monitoring progress, evaluating outcomes using objective quality indicators, and conducting systematic follow-up. All activities prioritize member-centered care and integration of Medicare and Medi-Cal services. The Quality Improvement Health Equity/Utilization Management Committee (QIHEC) oversees the program, ensuring adherence to the Plan-Do-Study-Act model, submission of the CCIP plan to CMS during the designated window, and annual updates via the HPMS Quality and Performance Module.

This policy applies to all Alliance staff including administrative staff, care managers, contracted providers, and all other entities involved in care of D-SNP members.

PROCEDURE

review

1. Plan (Q4 Each Year)

1.1. Methods for identifying members with multiple or severe chronic conditions:

1.1.1. Utilize multiple data sources to identify members who would benefit from CCIP participation:

1.1.1.1. Health Risk Assessments (HRAs): The goal is to attempt to complete the HRA within 90 days of enrollment, after a significant change in condition, and/or annually to assess chronic conditions, functional status, and social determinants of health (SDOH).

1.1.1.2. Claims Data: Analyze diagnosis codes to identify members with two or more chronic conditions or severe single conditions.

1.1.1.3. Risk Stratification Tools: Apply predictive models to identify high-risk members based on hospitalization history, medication use, and SDOH.

1.1.1.4. Provider Referrals: Incorporate input from primary care providers and specialists identifying members with complex needs.

1.1.2. Select conditions based on prevalence and performance gaps (e.g., diabetes with HbA1c >9%, cardiovascular disease with high readmission rates).

1.2. Set Objectives:

1.2.1. Establish SMART goals in the DSNP care plans based on objective, evidence-based quality indicators (e.g., HEDIS measure of HbA1c <8%, blood pressure <140/90 mmHg) to improve health status, reduce disparities, and enhance access.

1.3. Develop Interventions:

1.3.1. Design evidence-based strategies, including:

1.3.1.1. Care coordination via Interdisciplinary Care Teams (ICTs) developing Individualized Care Plans (ICPs) tailored to member specific chronic conditions and SDOH SMART goals.

1.3.1.2. Member education (e.g., diabetes self-management classes, telehealth monitoring).

1.3.1.3. Integration with Case Management for appropriate level of care (CICM vs. CM) and member-centric supports for complex cases and SDOH (e.g., transportation).

1.3.1.4. Provider training on evidence-based guidelines (e.g., American Diabetes Association standards).

1.4. Provider Network:

1.4.1. Ensure access to specialists (e.g., endocrinologists, cardiologist) and verify network adequacy per CMS/DHCS standards.

2. Do (Ongoing, January-December)

2.1. Implement Interventions:

2.1.1. Conduct HRAs within 90 days of enrollment to identify eligible members; incorporating chronic condition management and SDOH into ICPs..

2.1.2. Collaborate with CM for ICTs for each identified member, including providers, care managers, member/representative, and relevant quality improvement team members to implement ICPs and coordinate care.

2.1.3. Execute interventions, such as:

2.1.3.1. Regular ICT meetings to monitor progress.

2.1.3.2. Medication review post-transitions and annually.

2.1.3.3. Referrals to CICM for high-needs members and CS for SDOH

2.1.3.4. Culturally/linguistically appropriate education

2.2. Training:

2.2.1. Conduct annual training for staff and providers (≥ 90% completion) on chronic care guidelines, health equity, and CalAIM integration.

2.3. Care Transitions:
Follow DHCS requirements for protocols for transitions (from one level of care to another), ensuring timely following and ICT coordination ensuring follow up within 72 hours of transition.

3. Study (Quarterly)
3.1. Mechanisms for Monitoring Members:
3.1.1. Track member participation and progress using:
3.1.1.1. Data sources: HRAs, claims, encounter data, HOS, CAHPS, and telehealth monitoring outputs.
3.1.1.2. Metrics: Objective, clearly defined quality indicators based on current clinical knowledge (e.g., HEDIS measures: HbA1c control, blood pressure control, readmission rates).
3.1.1.3. Dashboards: Real-time monitoring tools stratifying data by race/ethnicity, language, and SDOH to identify disparities.
3.1.2. Conduct quarterly committee reviews to assess intervention effectiveness, participation rates, and barriers (e.g., low adherence to diabetes monitoring).
3.2. Performance Assessments:
3.2.1. Use quality indicators that are:
3.2.1.1. Objective: Based on validated metrics (e.g., HEDIS, CMS Star Ratings).
3.2.1.2. Clearly Defined: Specific thresholds (e.g., HbA1c <8%, hospital readmissions <15% within 30 days).
3.2.1.3. Evidence-Based: Grounded in clinical guidelines (e.g., American Heart Association for cardiovascular care).
3.3. Systematic Follow-Up:
3.3.1. Conduct ongoing follow-up via ICTs to monitor member health status (e.g., regular ICP reviews).

4. Act (Annually, Q4)
4.1. Evaluating Participant Outcomes:
4.1.1. Analyze changes in health status (e.g., pre/post HbA1c levels, reduced hospitalizations) using trending analysis.
4.1.2. Assess program impact on access, satisfaction (CAHPS scores), and equity.
4.1.3. Document outcomes demonstrating improvements.
4.2. Remedial Actions:
4.2.1. Conduct root cause analysis for gaps (e.g., low HRA completion and implement corrective action plans).
4.2.2. Escalate persistent issues to senior leadership.
4.3. Continuous Improvement:
4.3.1. Revise interventions based on study findings (e.g., enhance telehealth for non-compliant members).
4.3.2. Update program for subsequent PDSA cycles.
4.4. CMS Submission:
4.4.1. Compliance to submit annual CCIP description (PDSA model) via the HPMS Quality and Performance Module by December 31, starting the year after the initial plan submission.
4.4.2. Include evaluation results, outcome data, and plans for the next cycle.

5. Documentation and Compliance
5.1. Maintain records for 10 years per CMS requirements.
5.2. Conduct internal audits annually.

Review

5.3. Non-compliance triggers immediate corrective action plans, reviewed by the Quality Improvement Health Equity/Utilization Management Committee.

DEFINITIONS

- Chronic Care Improvement Program (CCIP): A CMS requirement focusing on evidence-based interventions to improve outcomes for members with chronic conditions over a three-year cycle, using the PDSA model.
- Chronic Condition: A long-term health issue requiring ongoing management, selected from CMS-approved categories based on member data and performance gaps.
- Social Determinants of Health (SDOH): Non-medical factors (e.g., housing, food-insecurity) impacting health outcomes.

AFFECTED DEPARTMENTS/PARTIES

Care Management
Compliance
Quality Improvement
Medicare Operations
Analytics
Utilization Management

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy
QI-101 Quality Improvement Health Equity Program

REVISION HISTORY

REFERENCES

- 42 CFR § 422.152: Quality Improvement Program
- 42 CFR § 422.101(f): Model of Care Requirements for SNPs.
- CMS Medicare Managed Care Manual, Chapter 5: Quality Improvement Program.
- CMS Medicare Managed Care Manual, Chapter 16b: Special Needs Plans.
- CMS CCIP and QIP User Guides (HPMS Quality and Performance Module).
- California Department of Health Care Services (DHCS): CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide – Contract Year 2026.
- National Committee for Quality Assurance (NCQA) SNP Guidelines.
- HEDIS Measures and CMS Star Ratings Technical Notes.

MONITORING

This policy will be reviewed annually.

review

POLICY AND PROCEDURE

Policy Number	UM-051
Policy Name	Timeliness of UM Decision Making and Notification
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/10/2016
Administrative Oversight Committee Approval Date	TBD~~12/29/2025~~

POLICY STATEMENT

Alameda Alliance will meet all applicable state and federal timely decision-making regulations, based in whole or in part on medical necessity in determining whether to approve, modify, or deny requests by providers.

POLICY

A. Alameda Alliance maintains current regulatory required timeliness standards for Utilization Review decision making and subsequent notification timeframes of the decision to both the Member and Provider.

   1. Regulations, licensure and contractual requirements, and accreditation standards require Utilization Management (UM) decisions (medical and behavioral health) and notifications to be made within required timeframes. When these required timeframes differ, Alameda Alliance has determined that the strictest standard takes precedence.

   2. The attached, "UM Timeliness Standards for Medi-Cal/ Group Care/D-SNP" document shows the timeliness standards specific to Medi-Cal, Group Care and D-SNP and is based on DHCS, DMHC, 42 CFR, Health and Safety Code §1367.01, & NCQA Standard UM 5.

   3. UM timeliness standards shall apply to all UM decisions whether the decisions are made on the basis of benefit coverage or on medical necessity, and to all UM decisions; approvals (favorable), partially favorable, modifications, denials (adverse), and terminations.

B. Measurement of Timeliness
   1. Counting days for Authorization Requests
      a. Day of receipt of request is counted as day zero.

b. Day following day of receipt of request is counted as day one, etc.

2. Counting Hospital Days
   a. Day of admission is counted as day one
   b. Discharge day is not counted.

C. Determining Day of Receipt of a Request for Authorization at AAH
   1. The day of receipt of a request for authorization is when the request is made to Alameda Alliance in accordance with its reasonable filing procedures, regardless of whether Alameda Alliance has all the information necessary to make the decision at the time of the request.

D. Receiving Authorizations During Business Hours and After Business Hours
   1. For requests received during normal business hours by UM phone line, fax, or portal the date/time received is logged as the same the telephone call, fax, or portal submission is received.

   2. For requests received by fax or portal submissions that are outside of normal business hours from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions, the date of receipt is logged as the same day/time the fax or portal submission is received.
      ~~1.~~a. Authorizations that need to be processed in order to maintain regulatory turn-around times, will be reviewed by the Health Care Services UM department staff to ensure compliance with timeliness.

   ~~2.~~3. Alameda Alliance informs providers, via the provider manual and website that Acute Inpatient, Post Stabilization or Urgent Discharge requests submitted after normal business hours should be made by calling UM On-call line 510-326-5271.
      ~~a. For requests received by fax or portal submissions that are outside of normal business hours from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions, the date of receipt is logged as the same day/time the fax or portal submission is received.~~

~~E.~~ E. Alameda Alliance has a process for determining urgency (expedited request status) following

~~When a pre-service request is marked as urgent (expedited) on the request form and the UM Clinical Reviewer~~ **42 CFR §422.570** definition of urgent (expedited)~~questions the urgency, the UM Clinical Reviewer will forward the request to a Medical Director reviewer to determine whether the request is urgent (expedited) or routine, based on the presenting referral information.~~

E. and may deescalate the request if it is determined that is does not meet the definition of urgent (expedited).
   ~~a. The Physician Reviewer is the only decision maker than can determine if a request needs to be deescalated from Urgent to Routine.~~

~~F.~~ F. Concurrent Review
   1. Care shall not be discontinued until the treating provider has been notified of the Plan's decision for denial and a ~~care~~ plan of care has been agreed upon by the treating provider which is appropriate for the medical needs of that patient.
      ~~1.~~a. The Alliance refers to Policy UM-052 Discharge Planning to Lower Level of Care for alignment with the process for creation and implementation of a plan for a safe discharge and the potential utilization of Administrative Days.

Formatted: Indent: Left: 0.75", No bullets or numbering

Formatted: Left, No widow/orphan control, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers

Formatted: Font: 12 pt

Formatted

Formatted

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted

PROCEDURE

A. AAH time frames for processing UM request per attachment grid A:

1. Performs medical review of authorization requests for covered benefits and Medical Necessity.

2. Makes utilization decisions within required decision timeframes, but also within a timely manner in order to expedite care to Members.

3. Sends notifications to the Member and Provider about UM decisions according to the applicable current regulatory timeliness standards while using the correct decision template per line of business

   (1) D-SNP: Integrated Coverage Decision Letter
   (2) Group Care: Notice of Action
   (3) MediCal: Notice of Action

B. The time of receipt of a request for authorization is when the request is made to AAH in accordance with its reasonable filing procedures, regardless of whether AAH has all the information necessary to make the decision at the time of the request.

~~1.~~ For requests received during normal business hours, the date of receipt is logged as the same day the telephone call, fax, or portal submission is received.

1. For requests received outside of normal business hours via the UM on-call phone line 510-326-5271, the date of receipt is logged as the same day the telephone call is received for requests pertaining to Hospital Discharges.

~~1.~~ For all Non-Hospital Discharge requests made outside of normal business hours, the requesting provider will submit the Authorization request via fax or the Alliance Provider Portal and the timestamp of submission will be applied. ~~.~~

2.

~~2.~~ For requests received by fax or portal that are outside of normal business hours ~~from Hospital Emergency Departments for Post Stabilization Care or planned or unplanned hospital admissions,~~ the date of receipt is logged as the same day/time the fax or portal submission is received.

3.

4. Determining whether a Pre-Service Review marked as Urgent (Expedited) meets the definition of Pre-Service Review, Expedited (Urgent).

5. When a pre-service request is marked as urgent (expedited) on the request form and the UM Clinical Reviewer questions the request meeting the **42 CFR §422.570** definition of urgent (expedited) , the UM Clinical Reviewer may call the requesting provider and educate them on the Alliance's process for deescalated authorization and offer the option to the provider to voluntarily modify the urgent (expedited) level to routine.

Formatted: Font: 11 pt, Not Expanded by / Condensed by

Formatted: Add space between paragraphs of the same style, No widow/orphan control, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers, Font Alignment: Auto

Formatted: Font: 11 pt, Font color: Auto

Formatted: Add space between paragraphs of the same style, Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5", No widow/orphan control, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers, Font Alignment: Auto

Formatted: Font: 11 pt, Not Expanded by / Condensed by

Formatted: Normal, Indent: Left: 0", Space Before: 0 pt, After: 0 pt, Add space between paragraphs of the same style, Font Alignment: Auto

Formatted: Font: 11 pt, Font color: Auto

Formatted: Indent: Left: 0.5"

Formatted: Indent: Left: 0.75", No bullets or numbering

Formatted: Indent: Left: 0.5"

Formatted: Font: 11 pt, Not Expanded by / Condensed by

Formatted: Indent: Left: 0.75", Space Before: 0 pt, After: 0 pt, Add space between paragraphs of the same style, No bullets or numbering, No widow/orphan control, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers, Font Alignment: Auto

Formatted: Font: 11 pt, Font color: Auto

Formatted: Font: 11 pt, Not Expanded by / Condensed by

Formatted: Indent: Left: 0.25"

Formatted: Normal, Indent: Left: 0.25", Space Before: 0 pt, After: 0 pt, Add space between paragraphs of the same style, Font Alignment: Auto

Formatted: Font color: Auto

Formatted: List Paragraph, Indent: Left: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Left, Indent: Left: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: Left: 0.25"

approval

6. If the provider agrees, the Clinical Reviewer can document the verbal request and process the authorization as routine.

    a. If the provider does not agree the Clinical Reviewer will forward the request to a Medical Director reviewer to determine whether the request is urgent (expedited) or routine, based on the presenting referral information.

    b. In those instances where the medical director disagrees with the requesting physician on urgency, a physician-to-physician phone call will be attempted.

7. The Physician Reviewer is the only decision maker than can determine if a request needs to be deescalated from Urgent to Routine.

~~3. If the Medical Director makes the determination that the request does not meet expedited criteria, then the Medical Director may ask the Nurse reviewer to obtain additional information from the requesting provider to support the decision and /or will attempt to contact the requesting provider via a physician-to-physician phone call.~~
~~a. For those non-supported expedited request then the Medical Director will change the status to routine and the UM Clinical Reviewer will follow notification policy~~

~~4. The UM Clinical Reviewer gives the name of the Medical Director and phone number to the requesting physician.~~

~~5. When a pre-service request is marked as Urgent (expedited) on the request form, the UM Clinical Reviewer will review for urgency and then refers to Medical Director for final determination in those cases perceived not to be urgent.~~

~~6. In those instances where the medical director disagrees with the requesting physician on urgency, a physician-to-physician phone call will be attempted.~~

C. When a pre-service request for pharmaceuticals (including injectables) and Part B Medication is received by FAX or portal in the UM Department, the UM staff Member receiving the submission notifies the Pharmacy staff ~~via the pharmacy group email~~ to enable Pharmacy to complete the pharmaceutical review.

    1. Physician Administered Drug reviews follow Pharmacy timeliness requirements (see RX-011 Decision and Notification Requirements)

    2. Therapeutic enteral formula reviews follow the medical UM timeliness requirements, (Pre-Service Urgent, Routine, Routine Current, Urgent Concurrent, Delay, Retrospective, etc.), per MMCD Policy letter 12-005 Enteral Feeding.

D. MONITORING

    1. The Utilization Management Department, on a routine basis, ~~reviews the results from the monthly authorization auditto ensure that all elements of timeliness are met. . The Department~~ audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.

DEFINITIONS / ACRONYMS

A. **Centers for Medicare and Medicaid (CMS)** a federal agency within the U.S.

Formatted: Font: 11 pt
Formatted: List Paragraph, Left, Indent: Left: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Indent: Left: 0.25"
Formatted: Font: 11 pt
Formatted: List Paragraph, Left, Indent: Left: 0.75", Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Indent: Left: 0.75"
Formatted: Font: 11 pt, Font color: Auto
Formatted: Normal, Indent: Left: 0.75", Hanging: 0.19", Tab stops: 1", Left
Formatted: Font: 11 pt
Formatted: Indent: Left: 0.5", No bullets or numbering
Formatted: Font: 11 pt
Formatted: Normal, No bullets or numbering
Formatted: Normal, Indent: Left: 0"
Formatted: Left, Indent: Left: 0", No widow/orphan control, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers
Formatted: Font: 11 pt, Font color: Auto
Formatted: Font: 11 pt, Font color: Auto

approval

Department of Health and Human Services that administers the nation's major healthcare programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Health insurance marketplace.

B. **Department of Health Care Services (DHCS)** is the State agency responsible for administration of the Medicaid (referred to Medi-Cal in California) Program, California Children's Services (CCS) Genetically Handicapped Persons Program (GHPP). Child Health and Disabilities Prevention (CHDP) and other health related programs.

C. **Department of Mental Health Care (DMHC)** is the state agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community base public mental health services statewide.

D. **Integrated Coverage Decision Letter** is a standardized notification issues by D-SNP plans when they make adverse integrated organizational determinations under 42 CFR § 422.631.

E. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

F. **Notice of action (NOA)** is a formal written notification issued by a Managed Care plan to inform members and providers that an adverse benefit determination has occurred

Formatted: Font: Bold

G. **Member** means any eligible beneficiary who has enrolled in Alameda Alliance for Health or Group Care.

H. **Post Stabilization Care** means Medically Necessary care following stabilization of an Emergency Medical Condition.

I. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services. NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

J. **Terminal Illness:** an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider

Formatted: Indent: Left: 0.5", No bullets or numbering

~~J.~~K. **Treating Provider Notification:** The Alliance aligns with the NCQA standards in UM 1 A Factors 1-4 pertaining to the notification of a denial to the Treating Provider. NCQA states that for urgent concurrent decisions, the organization may notify the provider (e.g., Hospital, rehabilitation facility, DME, home health) or Utilization Review department staff, with the understanding that the staff will inform the attending or treating practitioner.

approval

~~K.~~L. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

~~L.~~M. **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. It is a formal review of the coverage, Medical Necessity, efficiency, or appropriateness of health care services, which can be performed on a preservice, concurrent, or post service basis.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management Department (UM/ LTSS)
Compliance Department
Pharmacy Department

RELATED POLICIES AND PROCEDURES

CMP-400 Delegation Oversight
RX-011 Decision and Notification Requirements
UM-001 UM Authorization Processes
UM-051 Attachment A: Alameda Alliance for Health UM Timeliness Standards for Medi-Cal, Group Care and D-SNP

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

11/10/2016, 4/12/2018, 4/16/2019, 5/21/2020, 3/18/2021, 3/22/2022, 02/21/2023, 12/18/2024, 12/29/2025, 2/2/2026, 4/28/2026

REFERENCES

1. 2025 UM Standards; UM 5, Element A: Notification of Nonbehavioral Healthcare Decisions
2. 42 CFR § 422.631, 422.568(b)(2), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), 422.590(c), 422.590 (e), 422.631(a) and 422.633(f))
3. CA Health and Safety Code sections 1367.01(h)(1) through (5)
4. DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care
5. DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 2 (A), (B), (F), (G), and (I); Item 3 (A) through (J)
6. EAE SMAC (2025 Boilerplate, AIP D-SNP Model Materials)
7. MMCD Policy Letter 12-005 Enteral Feedings

approval

8. NCQA UM Standards Factor 1A sections 1-4.
~~8.~~9. Title 22 CCR Section 53855 (a) or any future amendments thereto.

approval

POLICY AND PROCEDURE

Policy Number	UM-056
Policy Name	Standing Referrals
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	TBD~~3/01/2018~~
Administrative Oversite Committee Approval Date	~~12/17/2025~~TBD

Purpose:
This policy establishes guidelines for issuing standing referrals to specialists for DSNP enrollees with chronic or disabling conditions that require ongoing specialty care to ensure continuity of treatment, reduce administrative burden and improve health outcomes.

Scope:
This policy applies to all enrollees who require ongoing specialty care due to chronic, complex, or disabling conditions. It outlines the processes to be followed by all healthcare providers, care managers and administrative staff.

POLICY STATEMENT

The Alliance provides standing referrals to specialists for enrollees who require continuing specialized medical care over a prolonged period of time as part of ongoing ambulatory care or due to a life-threatening, degenerative, or disabling condition. Services shall be authorized as a medically necessary proposed treatment identified as part of the enrollee's care or treatment plan utilizing established criteria and consistent with benefit coverage to enhance care coordination. Requests can be made by a member, Primary Care Physician (PCP) or specialist. The enrollee may receive a standing referral to a specialist or Specialty Care Center (SCC), in accordance with applicable rules and regulations in accordance with H&S Code section 1374.16. This policy supports our Model of Care for DSNP enrollees by

- Facilitating care coordination for vulnerable populations
- Supporting appropriate utilization of healthcare services
- Enhancing continuity of care/treatment
- Reducing barriers to specialty care for enrollees with complex needs
- Promoting an interdisciplinary approach to care

POLICY

1. The Alliance shall maintain a referral management process and may delegate the referral

approval

management process to delegated entities.

a) Delegated Entities shall maintain policies and procedures for referral management that includes reviews of requests for standing referrals for enrollees who require continuing specialty care or treatment for a medical condition or disease that is life threatening, degenerative, or disabling.

2. The Alliance shall establish and implement a procedure to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the Primary care Physician (PCP), in consultation with both the specialist, if any, and The Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or SCC.

a) The Alliance may require the PCP to submit a treatment plan during care or prior to the referral from the enrollee as determined by the Medical Director.

b) If a treatment plan is necessary during care and is approved by The Alliance, in consultation with the PCP, specialist, and enrollee, a standing referral shall be made in accordance with the treatment plan.

c) A treatment plan may be deemed unnecessary if The Alliance approves a current standing referral to a specialist.

d) The treatment plan may limit the number of visits to the specialist, limit the period of time during which visits are authorized, or require that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

3. The Alliance shall establish and implement guidelines for standing referral requests for enrollees that required specialized medical care over a period of time and who have a life- threatening, degenerative, or disabling condition, to a specialist or SCC that has expertise in treating the condition or disease for the purpose of having specialist coordinate he enrollee's health care.

a) The referral shall be made if the PCP, in consultation with the specialist or SCC, and Medical Director, determines that the continued specialized medical care is medically necessary for the enrollee.

b) The Alliance may require the PCP to submit a treatment plan during the course of care or prior to the referral for the enrollee, as determined by the Medical Director.

c) If a treatment plan is deemed necessary in the course of the care and isapproved by The Alliance, in consultation with the PCP, specialist. SCC and the enrollee, a referral will be made accordance with the treatment plan.

d) A treatment plan may be deemed unnecessary if The Alliance approves the applicable referral to a specialist or SCC.

4. Qualifying conditions for standing referrals that require ongoing specialist involvement

a) Chronic conditions include but are not limited to:

i. Diabetes
ii. Chronic heart failure
iii. Cardiovascular disorders
iv. Chronic lung disorders
v. HIV/Aids
vi. End-stand renal disease
vii. Cancer with active treatment
viii. Severe hematologic disorders
ix. Neurological disorders
x. Chronic/disabling mental health disorders

approval

b) Frequent specialty visits defined as four or more visits in a six-month period
c) Enrollees in case/care management programs for chronic conditions
d) Enrollees with disabilities requiring specialized healthcare services
e) Enrollees requiring ongoing care from a specialist functioning as a principal care provider for complex, chronic or disabling conditions

5. Standing referral to a specialist or SCC are provided within The Alliance's network to participating providers, unless there is no specialist or SCC within The Alliance's network that is appropriate to provide treatment to enrollee, as determined by the PCP in consultation with the Medical Director and as documented in the treatment plan.

6. Authorization and Referral Processes for Standing Referrals

a) Required documentation for Standing Referrals
   i. Diagnosis of a qualifying chronic/disabling condition
   ii. Clinical rationale supporting the need for ongoing specialty care
   iii. Anticipated frequency and duration of specialist visits needed
   iv. Specific services to be provided by the specialist
   v. Treatment goals and expected outcomes
   vi. Coordination plan between PCP and specialist

b) Authorization determinations for specialty services shall be processed accordance with Alliance's and/or its delegated entity's policies and procedures for referral management and within required time frames for standing referrals, as described in this policy, as described in AAH policy UM-057 Authorization Service Requests, and according to applicable regulations.
   i. Standing Referral authorization requests will be processed as a prospective review (a prior authorization request) to approve, deny, modify or delay based on medical necessity. (HSC 1367.01)
   ii. Services shall be authorized as medically necessary for proposed treatment identified as part of the enrollee's care or treatment plan utilizing established criteria and consistent with benefit coverage.
   iii. Determinations (authorized, denied, or modified) for a standing referral shall be made within three (3) business days from the date the request is made by the enrollee or the enrollee's PCP and all appropriate medical records and other information necessary to make the determination are received by The Alliance or delegated entity, as applicable.
   iv. Once the determination is made, the request for the standing referral shall be processed within four (4) business days of the date of the proposed treatment plan (if any), is submitted to a physician reviewer.
   v. The duration of an initially approved standing referral authorization shall be determined by the Medical Director, as medically appropriate, but shall not exceed one year. Standing referrals for mental health conditions up to 6 months with reassessment. Extensions beyond the initial authorization period requires clinical reassessment and documentation of ongoing need.

7. Timeliness Standards:

a) Determinations within:
   i. Three (3) business days from receipt of request for standing referral.

b) Processed within four (4) business days of the date of the proposed treatment plan, if any, is submitted to the Medical Director.

c) Notification - UM staff will generate a letter of notification of the decision to the Member, PCP and Specialist within:
    i. Two (2) calendar days of the final determination of request

8. Specialist Responsibilities
  a) Provide regular updates to the PCP regarding condition, treatment plan and progress of the enrollee
  b) Procedures, diagnostics or treatments not included in the standing referral require separate authorization
  c) Notify the Health plan and PCP of any significant changes in the enrollee's condition
  d) Participate in care coordination activities (medication reconciliation, coordination of services across settings, education regarding condition/treatment

---

PROCEDURE

1. Standing Referral Requests managed by delegates will be processed using the Delegated Entities UM Policy for Authorizations. Staff procedures may differ from The Alliance UM processes but Delegates will administer to the regulatory requirements.

2. Requests for a standing referral are initiated by the PCP/Specialist/Member after the Specialist and PCP agree on the Treatment Plan.

3. Referral requests are received via fax, online or phone through the UM designated mode of communication and processed by the Alliance's Utilization Management (UM) department.

4. UM department will process the referral request using guidelines from UM Authorization policy and procedure. The case will be routed to UM Nurse for review.

5. Upon receipt of a request for Standing Referral/Extended Specialty Referral, after the initial consultation has been completed, the UM Nurse will review the request and assures that the pertinent information is included in the referral:
    a) Member diagnosis
    b) Required treatment
    c) Requested frequency and time period
    d) Relevant medical records
    e) Other referrals, evaluation, or procedures, if any
        i. If additional information is needed the UM Nurse will request and allow the PCP/Specialist sufficient time to submit for determination per UM Policy - Timeliness of UM Decision Making.

6. UM Nurse will confirm the Treatment Plan includes review and signature of the PCP or Specialist validating the requested services. The UM Nurse forwards the completed request to the Medical Director for final determination.

7. Medical Director will review each request to ensure the Treatment Plan is appropriate and supported by the PCP and Specialist.

8. Medical Director will forward the case with the final determination to the coordinator of record

approval

for appropriate notifications to PCP/Specialist and Member.

9. Annual Renewals

   a) Standing referrals are valid for up to one calendar year unless indicated otherwise, from the date of the latest determination.
   b) Review of standing referral will be at least 30 days prior to expiration of the current authorization or when there is a significant change in their condition.
   c) The renewal request must include:
      - Updated clinical information
      - Treatment progress and outcomes
      - Rational for continued specialty care
      - Revised treatment plan goals if applicable
   d) UM Staff will process authorizations with the approved number of visits based on the approved Treatment Plan.

10. Monitoring/Oversight
    - The health plan will monitor utilization patterns related to standing referrals to ensure appropriate use and identify opportunities for improved care coordination
    - Number/types of referrals authorized
    - Denials/appeals related to standing referrals
    - Provider compliance with reporting requirements
    - Annual evaluation of the standing referral process as part of all over quality improvement
    -

11. Preventive Care:

    a) The specialty care provider is responsible for addressing the member's preventive health while the member is under his/her care for primary and specialty care services. Preventive services such as comprehensive history and physical exam, immunization, preventive screenings, and counseling, etc. must be addressed and be provided according to the periodicity guideline for preventive care for both adults and children, per recommendation by the US Preventive Services Task Force (USPSTF).

12. Monitoring

    a) The Utilization Management Department, on a routine basis, ~~reviews the results from the monthly authorization audit to ensure that all elements are met. Department~~ audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.

DEFINITIONS/ ACRONYMS

Benefits Determination: A denial of a requested service that is specifica11y excluded from a member’s benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.

approval

Criteria means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcomes.

Medical Necessity: Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

Medically Necessary (Group Care Program): Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. (Group Care Program Evidence of Coverage)

Medically Necessary (Medi-Cal Program): means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical Practitioner, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

Formatted: Indent: Left: 0.07", Hanging: 0.36"

- Consistent with nationally accepted standards of medical practice:
  - "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer- reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.
  - For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
  - For purposes of covered services for Medi-Cal Members, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and
    - When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT Supplemental Services as defined in Title 22, 51340 and 51340.1.

Medical Necessity Determination means UM decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services; and care or service that could be considered either covered or non-covered, depending on the circumstances.

Member means any eligible beneficiary who has enrolled in the Alliance and who has been assigned to or selected a Plan

Non-Contracted Provider is a provider of health care services who is not contractually affiliated with

AAH

Prior Authorization or Prospective Review: A type of Organization Determination that occurs prior to services being rendered.

Provider means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

- NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

Specialty Care Center means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Standing Referral means a referral to see a specialist for a specified period of time without requiring new referrals for each visit up to one year

Utilization Management (UM) means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources

D-SNP (Dual eligible special needs plan): A mediocre advantage plan that exclusively enrolls individuals who are entitled to both Medicare (Title XVIII) and Medicaid (title XIX)

AFFECTED DEPARTMENTS/PARTIES

Utilization Management

RELATED POLICIES AND PROCEDURES

1. UM-001 - Utilization Management
2. UM-051 -UM Timeliness Standards
3. UM-057 -Authorization Request Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

3/01/2018, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 9/19/2023, 8/17/2024, 12/17/2025, 2/6/26, 4/28/26

approval

REFERENCES

1. California Health and Safety Code -HSC § 1374.16
2. DHCS Contract Exhibit A, Attachment 9, Access and Availability, Section 7
3. California Welfare and Institutions Code Section 14450.5
4. California Health and Safety Code - HSC § 1367.01
5. Title 42 CFR 422.2, 101(f), 107, 631

Formatted: Font color: Gray-95%

Formatted: Font color: Gray-95%

Formatted: Indent: Left: 0.18", Hanging: 0.17", Space Before: 0.35 pt, After: 0 pt, Tab stops: 0.35", Left + Not at 0.43"

approval

POLICY AND PROCEDURE

Policy Number	UM – 068
Policy Name	Tertiary and Quaternary Review Process
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	01/21/2021
Administrative Oversight Committee Approval Date	~~12/17/2025~~TBD

approval

POLICY STATEMENT

Alameda Alliance for Health and Alameda Alliance Wellness ("The Alliance") ensures that members are redirected to a contracted facility that will be able to provide appropriate level of care, efficient, and expedient access to care. The Alliance makes UM decisions only on the appropriateness of care and service and existence of coverage.

PURPOSE

The purpose of this policy is to establish and implement the Tertiary and Quaternary Review Process. This policy is implemented to outline the standard process utilized in reviewing appropriateness of referrals and transitions to a tertiary and quaternary level of care. This will ensure consistency of all reviews both internally and externally. This will result in the timely transition of members to the right level of care at the right time and high-quality outcomes.

PROCEDURE

A. The Alliance maintains a network of providers that is supported by written agreement and is sufficient to provide adequate access to care. The Alliance maintains networks that meet time/distance standards and cover dual-eligible needs including by not limited to advanced cardiac care, neurosurgery, specialized cancer treatment and burn treatment units. The Alliance also maintains networks that support multi-organ transplants. Tertiary and Quaternary care referrals are reviewed for the purpose of medical overview, preventing overtreatment, and to avoid unnecessary treatment that may result in lack of patient benefit and bear potential cause of harm.

B. Within the Alliance's network that delivers both tertiary and quaternary care includes the following National Cancer Institute (NCI) designated comprehensive Cancer Centers:
   1. Alta Bates Summit Comprehensive Cancer Center, Adult Cellular Therapy Program (Bone Marrow Transplants only)
   2. University of California, San Francisco Helen Diller Family Comprehensive Cancer Center
   3. Stanford Cancer Institute, (includes Oncology and Bone Marrow Transplant (BMT) Services) and Major Organ Transplants (MOT)

C. Requests for specific tertiary and quaternary centers (either within or outside the network) may be subject to redirection to another tertiary or quaternary care center with regards to access that may be based on several factors. The Alliance considers the following referrals to tertiary or quaternary care centers as medically necessary:

   1. Referrals generated from specialists in the community who document a medical need for a higher level of care in the form of a specialized diagnostic approach, treatment, or procedure, or screening.
   2. Referrals when a continuity of care issue is documented and meets regulatory requirements for continuity of care coverage.
      a. For example, if the Member is in the midst of an active course of treatment for a medical or behavioral need and
      b. the Member has seen the tertiary or quaternary care provider within the last 12 months, referral authorization for continuity of care or active course of treatment would be indicated and
      c. The Provider must be willing to accept rates with the health plan, be a registered Medi-Cal provider, and
      d. Does not have documented quality of care concerns.
      e. For D-SNP Line of business, the member or member's representative can submit a request for Continuity of Care via telephone to the plan.
   3. Referrals whose redirection may result in delay of necessary medical diagnostic services or treatment. Ancillary medical requests (e.g., radiology, laboratory studies) must be considered for adequate coverage in alternative settings or redirections that could result in potential delays in treatment decisions.
   4. Referrals to secondary specialties related to the primary specialty at a tertiary or quaternary care center where an active course of treatment exists.
      a. For example, a Member with NYHA Class IV congestive heart failure may be followed by a tertiary or quaternary care center cardiologist. If the Member also has co-morbid pulmonary hypertension requiring pulmonary specialty consultation, approving the tertiary or quaternary pulmonary consultation would be appropriate to allow for multi-disciplinary collaboration in the Member's overall care plan.
      5. Requests for consultation with specialties that have limited access in the community or that are not available in the community network setting. Requests are reviewed and evaluated based upon individual medical or behavioral needs.
         a. The request may include, but are not limited to the following specialties; neuro-oncology, complex surgical-oncology and

Formatted: Left

gynecologic-oncology, neurosurgery, infectious disease and perinatology.

D. The Alliance considers the following requests to tertiary or quaternary centers as appropriate for potential redirection to in-network community-based specialists, provided redirection does not compromise care:
   1. Hematology/ Oncology consultation for cancers that, based on available documentation, **do not** demonstrate;
      a. advanced stages or metastasis,
      b. have not failed (or are deemed not likely to fail) standard care available in the community,
      c. and/or are not rare or aggressive cancer types.
   2. Specialty requests for consultations when specialists with appropriate access standards that can provide equivalent services are available in the community.
   3. Requests for ancillary services (e.g., radiology or laboratory testing) that will not result in delay of treatment or coordination of care.
   4. Specialty consultation requests that do not therapeutically relate to another specialty for which the Member is being followed in a tertiary or quaternary care center, and for which a community-based specialist has appropriate access and can provide equivalent services.
   5. Requests for continuity of treatment of stable Members in the maintenance phase of their medical condition.

E. The Alliance considers the following requests to tertiary or quaternary centers as **not** appropriate for potential redirection to in-network community-based specialists:
   1. A complex cancer diagnosis that would support a referral to a tertiary or quaternary center.
   2. Members who have lost eligibility with the Alliance.

F. Process for when a member is redirected to a community-based specialist:
   1. When requested services are denied, modified or deferred, a Notice of Action (NOA) or Coverage Decision Letter (CDL) is sent to the member and requesting provider in accessible formats. The NOA/CDL is a written notification of the UM decision that includes a clear and concise denial reason, a reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based, and a statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
   2. The NOA or Coverage Decision Letter (CDL) also includes the members' right to file an appeal of the determination, for D-SNP this is a unified Medicare and Medicaid appeals process
   3. The Alliance's appeal process is outlined in policy and procedure *G&A-008 Adverse Benefit Determination Appeal Process*.

DEFINITIONS / ACRONYMS

approval

1. **Complex Cancer Diagnosis:** an advanced stage (Stage IV) or metastatic cancer, members who have failed (or are deemed likely to fail) standard care available in the community, and/ or are rare or aggressive cancer types.
2. **Tertiary Care**: specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital.
3. **Quaternary Care**: used as an extension of tertiary care in reference to advanced levels of medicine with are highly specialized and not widely accessed. This could include experimental medicine, screening modalities and some types of uncommon diagnostic or surgical procedures; these services are usually only offered in a limited number of health care centers.

AFFECTED DEPARTMENTS/PARTIES

- Utilization Management Department

RELATED POLICIES AND PROCEDURES

- UM-001 Utilization Management Program
- UM-036 Continuity of Care
- UM-051 Timeliness of UM Decisions
- UM-054 Notice of Action
- UM-057 Authorization Request
- G&A-008 Adverse Benefit Determination Appeal Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- General Overview of the Prior Authorization Process Workflow

REVISION APPROVAL HISTORY

01/21/2021, 3/22/2022, 2/21/2023, 3/19/2024, 12/18/2024, 12/17/2025, 2/3/2026, 4/28/2026

REFERENCES

- CA Health & Safety Code § 1370.6 (2021)
- 42 CFR 422.107
- DHCS APL 25-006 Timely Access Requirements
- Health and Safety Code (H&S) 1367.03
- Senate Bill (SB) 332 (Chapter 724, Statutes of 2021)
- Senate Bill (SB) 225 (Chapter 601, Statues of 2022)
-
- Department of Health Care Services All Plan Letter 18-008, Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care, December 7, 2018.

Formatted: Font: 11 pt

Formatted: Space After: 0 pt, Line spacing: single

approval

- SB 987, Portantino. California Cancer Care Equity Act.

MONITORING

1. Internal Monitoring
   a. Auditing is done on a quarterly basis by the Utilization Management Department. The audit findings are presented to the Utilization Management Sub-Committee. Routine audits include a review of clinical decision making including a review of the appropriateness of the approval or denial of services based on medical necessity.
   b. The Utilization Management Department, on a routine basis, ~~reviews:~~
      i. ~~Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department~~ audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
      ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.

2. Staff Training
   a. Staff training is conducted for new hires and on an ad-hoc basis by either the Manager of Outpatient Utilization Management or the Utilization Management Director or Medical Director. Training would consist of changes to any applicable state regulation, and implementation of new or updated policy and procedures.

approval

POLICY AND PROCEDURE

Policy Number	UM-D-005
Policy Name	Review of Admissions, Discharge, and Transfer Files
Department Name	Health Care Services
Department Officer	Chief Medical Director
Policy Owner	Director, Utilization Management
Lines of Business	D-SNP
Effective Date	9/17/2025
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Wellness is committed to systematically reviewing admissions, discharge and transfer files (ADT) to ensure compliance with federal and state regulations, promote seamless care coordination, and enhance health outcomes for D-SNP members. This policy supports the California Advancing and Innovating Medi-Cal (CalAIM) initiative and Centers for Medicare & Medicaid Services (CMS) requirements by facilitating timely utilization oversight, reducing preventable readmissions, and ensuring adherence to the D-SNP Model of Care (MOC).

This policy governs the review of hospital admission, discharge, and transfer (ADT) logs and related utilization data for D-SNP members. It applies to all processes involving the collection, review, and analysis of ADT feeds to support care coordination, quality improvement, and regulatory compliance. The policy encompasses interactions with contracted hospitals, Independent Practice Associations (IPAs), and internal teams responsible for managing D-SNP member care.

PROCEDURE

1. Data Collection
   a. Contracted hospitals/IPAs submit ADT logs within 24 hours of an event via a secure, HIPAA-compliant platform (EREX).
   b. Logs must include member ID, admission/discharge dates, primary diagnosis, and discharge disposition.
   c. UM staff verify ADT accuracy against member records within 48 hours, resolving discrepancies with hospitals promptly.

2. Concurrent Review
   a. UM staff review daily ADT to confirm medical necessity using evidence-based criteria (e.g., NCD, LCD and MCG).
   b. Collaborate with hospital case managers and the Alliance case manager to align care with the member's Interdisciplinary Care Plan (ICP).
   c. Document findings, including prior authorizations for medications or durable medical equipment (DME), in the clinical documentation system.
   d. Frequency: Daily for active inpatient cases.

3. Discharge Planning Review
   a. The CM /Transitional Care Services staff review ADT files to confirm:
      i. Alignment of discharge plan with ICP and CalAIM community support requirements.
      ii. Arrangement of medications, DME, and follow-up appointments within 7 days.
      iii. Contact members/caregivers within 3 business days post-discharge to verify plan execution.
      iv. Update ICP based on findings.

4. Data Privacy and Compliance
   a. Log reviews adhere to HIPAA and HITECH standards for protecting health information.
   b. Access is limited to authorized personnel with role-based permissions.
   c. Non-compliance or breaches are reported to the Compliance Department, CMS and DHCS within 72 hours.

DEFINITIONS

- Hospital Logs: Electronic or written records documenting D-SNP member admissions, discharges, transfers, diagnoses, and discharge dispositions.
- CalAIM: California Advancing and Innovating Medi-Cal, a DHCS framework to integrate and improve care for dual-eligible populations.
- HRA: Health Risk Assessment, a tool to assess members' physical, psychosocial, and functional needs.
- ICP: Individualized Care Plan, a tailored plan based on HRA findings to address member-specific needs.

AFFECTED DEPARTMENTS/PARTIES

- Utilization Management (UM) Department: Reviews logs for medical necessity and discharge planning.
- Care Coordination Department: Updates ICPs and coordinates post-discharge services based on log data.
- Quality Improvement (QI): Analyzes logs for utilization trends and quality metrics.
- ~~Compliance Department: Ensures regulatory adherence and oversees audits.~~
- Contracted Hospitals/IPAs: Submit timely and accurate hospital logs to the D-SNP plan.

- Information Technology (IT) Department: Maintains secure systems for log submission and storage.

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy: 9/17/2025, 2/3/26, 4/28/2026

REFERENCES

- CMS Medicare Advantage D-SNP Regulations (42 CFR Part 422)
- DHCS CalAIM Strategic Plan (2023-2027)
- Bipartisan Budget Act of 2018 (Hospital Admission Notification Requirements)
- California Health and Safety Code
- HIPAA and HITECH Act

MONITORING

- DepartmentalInternal Audits: Audits will be conducted by the Utilization Management Department of the log review processes to verify adherence to CMS, DHCS, and CalAIM requirements.
- Hospital/IPA Audits: Annual audits ensure contracted entities submit timely and accurate logs.
- Performance Metrics: Monthly reports track admission rates, readmission rates (within 30 days), and discharge plan compliance, reviewed by the QI Committee.
- ~~Corrective Actions: Audit findings trigger corrective action plans, monitored by the Compliance Officer.~~
- Continuous Improvement: Log review outcomes inform quality improvement initiatives, targeting care gaps and health equity per CalAIM goals.

Formatted: Indent: Left: 0.5", No bullets or numbering

approval

POLICY AND PROCEDURE

Policy Number	UM-D-009
Policy Name	Integrated Organization Determinations
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	D-SNP
Effective Date	01/01/2026
Administrative Oversight Committee Approval Date	~~12/29/2025~~TBD

POLICY STATEMENT

Alameda Alliance Wellness is committed to delivering integrated organization determinations for D-SNP members through a standardized, timely, and equitable process that ensures a single, coordinated authorization decision and unified member notification for all Medicare and Medi-Cal benefits. This policy complies with CMS and DHCS integrated care requirements.

This policy applies to all D-SNP members, their authorized representatives, and providers acting on their behalf. It covers integrated organizational determinations for all covered services, including Medicare Parts A, B, D, and Medi-Cal benefits.

PROCEDURE

1. Intake and Identification
   a. Requests for integrated organization determinations may be submitted orally or in writing by members, their representative, or provider.
   b. All prior authorization and service requests are screened to confirm eligibility.
   c. Requests are routed through the clinical management system to the designated UM Coordinator.
2. Integrated Review Process
   a. A single review is conducted by a UM nurse and/or medical director trained in both Medicare and Medi-Cal benefits to issue one determination covering all applicable benefits.
   b. Coverage evaluated as follows:
      i. Medicare Services: Apply Medicare Criteria (e.g., NCD, LCD, MCG)
      ii. Medi-Cal Services: Apply Medi-Cal guidelines (e.g., APLs, provider bulletins)

c. The rationale for both Medicare and Medi-Cal components is documented in a single determination record in the clinical management system.

3. Timeframe Requirements
   a. Timeframes align with the most stringent Medicare and Medi-Cal requirements. Refer to UM-051, Timeliness of UM Decision Making and Notification.
4. Unified Notification
   a. A single integrated Coverage Decision Letter (CDL) is issued, including:
      i. Decision outcome and rationale for all applicable benefits.
      ii. Benefit authority (Medicare, Medi-Cal, or both).
      iii. Appeal and grievance rights, including timeframes and procedures.
      iv. Compliance with CMS model notices and California language access requirements.
   b. For expedited request denials, prompt oral notification is provided when feasible, followed by written notification within 3 calendar days.
5. Documentation and Systems
   a. All decisions, communications, and notices are recorded in the clinical management system and maintained for audit purposes.
   b. Data is securely shared with care coordinators and delegated partners to ensure seamless service delivery.
6. Oversight and Quality Assurance
   a. The Utilization Management Department conducts ~~M~~monthly audits verify compliance, including:
      i. Timeliness of decisions and notifications
      ii. Correct application of Medicare and Medi-Cal criteria.
      iii. Accuracy and completeness of unified notices.
   b. Annual training ensures staff are proficient in federal and state requirements.

DEFINITIONS / ACRONYMS

- Organization Determination: A decision by the plan regarding coverage of requested services or items.
- Integrated Determination: A single review process evaluating both Medicare and Medi-Cal criteria, resulting in one unified authorization decision and notification.

AFFECTED DEPARTMENTS/PARTIES

UM

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

---

approval

REVISION APPROVAL HISTORY

New Policy: 12/29/2025, 4/28/26

REFERENCES

- 42 CFR §§ 422.568, 422.570, 422.572, 422.631 (Integrated Organization Determinations and Timeframes)
- 42 CFR § 422.562 (Unified Grievance and Appeals Process for D-SNPs)
- California DHCS D-SNP Policy Guide
- DHCS-MMCD Policy Letter 22-001 (Unified Processes for D-SNPs)

MONITORING

The ~~Compliance and~~ Utilization Department will review this policy annually for compliance with regulatory and contractual requirements.

approval

POLICY AND PROCEDURE

Policy Number	UM-052
Policy Name	Discharge Planning to Lower Level of Care, (Including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days)
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	05/25/2017
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

PURPOSE

To establish standardized procedures for all staff involved in discharge planning, UM, and care coordination for Alliance members discharge planning to lower levels of care and appropriate utilization of administrative days for members with pending placement to lower levels of care.

POLICY STATEMENT

1. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.
2. The attending physician is responsible for evaluating the post - acute admission needs of the member and determining the type of recovery prior to discharge.
3. Administrative bed days will be reviewed under the inpatient authorization process. Administrative bed days will be reviewed for authorization by Alameda Alliance for Health (AAH) / Alameda Alliance Wellness while the member is in an acute care inpatient facility which provides a higher level of care than what is needed currently by the member. Days will be authorized when the appropriate guidelines below are followed while the patient remains in an acute care inpatient facility and is awaiting placement in recovery care facilities. Policy aligns with DHCS definition of Acute Administrative Days (AAD), inpatient stay days for Medi-Cal recipients who no longer require acute hospital care, and fall into lower level of care types described in TAR Criteria for AAD.

Formatted: Space After: 0 pt

4. Post-Acute care Admission to Lower Level of Care

a) Lower level of care services will be provided to any member who receives a physician's order for transfer to a recovery facility appropriate for his/her medical needs.

5. Transfer to the appropriate recovery facility will be made in a timely manner.

Formatted: Space Before: 0 pt, After: 0 pt

a) The following settings are considered appropriate for post-acute care admission into lower level of care:

i. Nursing Facility (Skilled and/ or Long-Term Care Custodial)
ii. Sub-Acute Care Facility
iii. Acute Rehab Facility
iv. Long-Term Acute Care Facility (LTAC)
v. Intermediate Care Facility for the Developmentally Delayed (ICF/DD)
vi. Medical Respite Facility

6. Hospital Stays where members are pending placement to the following locations do not qualify for Acute Administrative Days

Formatted: Indent: Left: 0.25"

a) Inpatient psychiatric facility
b) Homeless Shelter
c) Respite Care Center
d) Board and Care Facility
e) Acute Rehabilitations Facility
f) Outpatient Dialysis Clinic for ongoing treatment
g) Home with home health services
h) Nursing Facility stays for Hospice
i) Nursing Facility swing bed when the nursing facility is not at full capacity
j) Patients who have an active seven- day bed hold from a transferring nursing facility

Formatted: List Paragraph, Indent: Left: 0.5", Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: First line: 0"

PROCEDURE

A. Discharge Planning to a Lower Level of Care Facility

Formatted: Space Before: 0 pt, After: 0 pt

1. Discharge planning begins at the time of admission within 24 hours of admission in accordance with 42 CFR § 482.43(a) for unscheduled patient stays and prior to admission for elective inpatient stays and continues throughout the patient's stay. The patient's progress is evaluated in order to plan for a timely discharge to the appropriate level of care and provision of Transitional Care Services (TCS).

a) At the time of admission, the hospital discharge planner, case manager or social worker conducts a discharge planning evaluation as required by 42 CFR § 482.43(b) and documents the member's discharge planning and TCS needs and associated barriers to discharge in a note.

b) The discharge plan shall address the patient's goals and treatment preferences, in accordance with 42 CFR § 482.43(c)(5)

Formatted: Indent: Left: 0.5", Hanging: 0.5", Space Before: 0 pt

c) The discharge plan will include a comprehensive list of arrangements for post-

collaboration

acute care services the patient will need.

d) Transitional Care Services (TCS) includes:

i. Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility to facilitate the participation of the Care Manager with the discharge planning and follow up.

ii. Discharge Risk Assessment

iii. Discharge Planning document

iii.

e)

e) A full description of the Alliance TCS program is found in *CM-034 Transition of Care policy* and *CM-D-034 Transition of Care policy*

2. The discharge plan will be coordinated with the attending physician, the member and/or family, the identified TCS Care Manager, the hospital interdisciplinary staff and lower-level placement facilities. Evaluation of the discharge plan is included in the concurrent review sessions between the Alliance UM Nurse/Reviewer, the Alliance Medical Director and the facility's discharge planning staff. Discharge placement procedures to lower level of care facilities (in network or out of network) is coordinated with the facility and agreed upon prior to placement.

3. The Alliance UM Nurse/Reviewer reviews member's needs using the Medi-Cal guidelines and the MCG guidelines for recovery facility placement. Medically necessary services are reasonable, necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR § 440.230

4. The Alliance UM Nurse/Reviewer will verify benefits and provide the authorization decision to the hospital for appropriate placement.

5. When significant barriers to placement exist, the Alliance UM Nurse/Reviewer will assist the facility in locating accepting facilities capable of managing the members' care needs. Discharge barriers could include:
   a) Bariatric Needs
   b) Bedside Dialysis Needs
   c) Isolation
   d) Social Determinants of Health (Including Homelessness)
   e) Long-Term Care (Custodial) Placements
   f) Aggressive or Wandering Behaviors
   g) History of Member Elopement/ AMA

6. The AAH UM staff will assist in contacting potential accepting facilities
   a) If there are no INN options available, the AAH UM staff will initiate the Letter of Agreement (LOA) process for Out of Network (OON) facilities that would accept the member for care. The procedure for discharge to the out

Formatted: Space Before: 0 pt

Formatted: Space Before: 0 pt

Formatted: Normal, Indent: Left: 1.06", Hanging: 0.19", Space Before: 0 pt, Widow/Orphan control, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers, Tab stops: Not at 0.81"

Formatted: Space Before: 0 pt, After: 0 pt

Formatted: Space Before: 0 pt, After: 0 pt

Formatted: Indent: Left: 0.5", Hanging: 0.5", Space Before: 0 pt, After: 0 pt

Formatted: Space Before: 0 pt, After: 0 pt

Collaboration

of network facility will be coordinated with the OON facility and agreed upon before the discharge to ensure that the Member's needs are met during and after the transition. The option to create an ongoing contract with the OON facility will be offered.

b) Case will be discussed at Extended Length of Stay Rounds to identify placement options.

c) If Length of Stay (LOS) is prolonged, the AAH UM staff will escalate the case to AAH clinical and/or operational leadership to develop strategies to locate appropriate placement.

Formatted: Space Before: 0 pt, After: 0 pt

7. Strategies to locate placement may include working administratively with facilities to develop capacity to manage the member's needs, contacting DHCS to assist in problem resolution, and/or identify contractual opportunities regarding placement.

Formatted: Space Before: 0 pt, After: 0 pt

B. Granting Administrative Days Once Patient No Longer Meets Medical Necessity for Acute Patient Stay

1. AAH will authorize administrative bed days in facilities that have Administrative Day level of care in their contract with AAH, when:
- The patient no longer meets acute care criteria, as determined by utilization review
- Documented evidence shows that placement at an appropriate lower level of care is not immediately available
- The Alliance has actively engaged in placement efforts
- The patient requires a level of care not available in the community
- Administrative day criteria are consistent with Title 22, California Code of Regulations (CCR), Section 51124
- Acute Administrative Days (AAD) are inpatient stay days for Medi-Cal recipients who no longer require acute hospital care, and may fall into one of the 3 types below:
    1. Nursing Facility including NF-A, NF-B and Subacutes
    2. Obstetric Administrative Days for pregnant members who do not need an acute level of care but have treatment needs that require medical and nursing monitoring not available in another setting.
    3. Tuberculosis administrative days for members with confirmed or suspected TB, who no longer require acute level of care, and continue to require isolation to prevent the spread of TB disease in the community.

Formatted: Indent: Left: 0.75", First line: 0", Tab stops: 0", List tab + Not at 0.5"

Formatted: paragraph, Indent: Left: 1.25", First line: 0", Space Before: 0 pt, After: 0 pt, Outline numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 2 + Alignment: Left + Aligned at: 0.25" + Tab after: 0.5" + Indent at: 0.5", Adjust space between Latin and Asian text, Adjust space between Asian text and numbers, Font Alignment: Baseline, Tab stops: 0", List tab + Not at 0.5"

AND if the hospital follows the following guidelines.

Formatted: Space Before: 0 pt, After: 0 pt

2. Day 1:

a) Hospital staff will send a fax blast to a minimum of ten (10) contracted facilities and send confirmation to the Alliance Nurse/Reviewer. ~~Deadline will be 3:00 pm.~~

b) If the above requirements are completed and member is not placed in a facility:

c) The administrative day will be authorized.

d) The Hospital should plan to initiate the outreach outlined in Day 2 below.

3. Day 2:

a) Hospital staff will attempt to find appropriate placement for the member by calling at least ten (10) contracted lower level of care facilities.
b) Hospital staff will send the list of facilities contacted to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. ~~The deadline will be 3:00 pm.~~
c) If the above requirements are completed and member is not placed in a facility:
d) The administrative day will be authorized
e) The Hospital should plan to initiate the outreach outlined in Day 3 below

4. Day 3:
a) Hospital staff will call the Alliance UM Nurse/Reviewer for assistance if no placement has been made.
b) Hospital staff will continue to call at least five (5) facilities, send the list of facilities contacted to the Alliance UM Nurse/Reviewer assigned to the hospital where the member is admitted~~.~~
c) Hospital staff will record the list of facilities contacted and send it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. ~~The deadline will be 3:00 pm.~~
d) The Alliance UM staff will send a fax blast to both contracted facilities and non-contracted facilities.
e) The Alliance UM Nurse/Reviewer will also assist by contacting contracted and non-contracted facilities in order to facilitate placement
f) If the above requirements are completed and member is not placed in a facility:
g) The administrative day will be authorized
h) The Hospital should continue to initiate the outreach outlined in Day 4, and Day 5 and ongoing.

5. Day 4:
a) Hospital staff will call at least five (5) facilities and send the list of facilities contacted it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. ~~The deadline will be 3:00 pm.~~
b) The Alliance UM Nurse/Reviewer may also assist by contacting contracted and non-contracted facilities in order to facilitate placement

Formatted: Space Before: 0 pt, After: 0 pt

6. Day 5: and ongoing days until discharge
a) Hospital staff will call at least five (5) facilities and send the list of facilities contacted it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.
b) The Alliance UM Nurse/Reviewer may also assist by contacting contracted and non-contracted facilities in order to facilitate placement
c)The Alliance Nurse/Reviewer will escalate the case to the Managers
d) For complex placements, the Alliance Medical Director may be consulted for medical related issues.

Formatted: Space Before: 0 pt, After: 0 pt

7. Regarding placement efforts on weekends and holidays:

collaboration

a) Placement calls are not required on weekends and state holidays (Christmas Eve and New Year's Eve are not considered state holidays)
b) If there are no calls on Friday, or the call list is insufficient/incomplete, then Friday, Saturday and Sunday may not be approved.
c) If there are no calls or an insufficient/incomplete call list on the day prior to a holiday, then that day and the holiday may not be approved.

Authorization Process

1. The hospital shall submit request for administrative days to the health plan's utilization management department within 24 hours of determining that patient no longer meets acute care criteria.
2. The request must include:
   a. Clinical summary demonstrating that patient no longer meets acute care criteria
   b. Documentation of LLOC needs
   c. Documentation of placement efforts
   d. Barriers to discharge, if any
3. Initial authorization for administrative days will be for up to 5 days, with subsequent reviews conducted at minimum every 5 days.

Continued Authorization Requirements

1. For continued authorization of administrative days, the hospital must provide:
   a. Documentation of ongoing placement efforts
   b. Record of at least five appropriate facilities contacted within the past 7 days
   c. Updates on the patient's condition and LLOC needs
   d. Strategies to address identified barriers to placement.

C. Delegation Oversight

1. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities must make sure that hospitals in which their delegated review patients have been admitted comply with the above referenced process with the attendant documentations. Refer to UM-060 for delegation oversight process.

DEFINITIONS

Discharge Planning - The activities that facilitate a patient's movement from one health care setting to another, or to home. It is a multidisciplinary process involving physicians, nurses, social workers, and possibly other health professionals; its goal is to enhance continuity of care. It begins on admission.

Formatted: Indent: Left: 1", Hanging: 0.19", Outline numbered + Level: 3 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Indent at:
Formatted: Font: (Default) Segoe UI, 9 pt
Formatted: Space Before: 0 pt, After: 0 pt
Formatted: Space Before: 0 pt, After: 0 pt
Formatted: Indent: Left: 0.5", Space Before: 0 pt, After: 0 pt, No bullets or numbering
Formatted: Space Before: 0 pt, After: 0 pt
Formatted: Indent: Left: 1", Space Before: 0 pt, After: 0 pt, No bullets or numbering
Formatted: Space Before: 0 pt, After: 0 pt
Formatted: Indent: Left: 0.5", Space Before: 0 pt, After: 0 pt, No bullets or numbering
Formatted: Font: Bold
Formatted: Font: Bold
Formatted: Space Before: 0 pt, After: 0 pt
Formatted: Indent: Left: 1", Space Before: 0 pt, After: 0 pt, No bullets or numbering
Formatted: Space Before: 0 pt, After: 0 pt

collaboration

Administrative Days - Inpatient stay days for a member who no longer require acute hospital care and is awaiting placement in a nursing home or other subacute or post-acute care facility.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program
UM-003 Concurrent Review and Discharge Planning Process
UM-051 Timeliness of UM Decision Making
UM-054 Notice of Action
UM-057 Authorization Request
UM-060 Delegation Management and Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

~~Attachment #1 - Request to Discharge Members to Lower Level of Care Proof of Placement Log~~N/A

REVISION APPROVAL HISTORY

5/25/2017, 03/01/2018, 07/06/2018, 09/06/2018, 11/21/2019, 3/18/2021, 3/22/2022, 6/28/2022, 02/21/2023, 3/19/2024, 9/17/2025, 4/28/26

REFERENCES

~~DHCS Contract, Exhibit A, Attachment 8~~
~~DHCS APL 13-005, Requirements for Hospital Administrative Days and Acute Administrative Days~~
~~California Welfare and Institutions Code Section 14132.3, Medi-Cal managed care plans and administrative days~~
~~CDPH AFL 10-21~~
42 CFR §440.230
42 CFR § 482.43(a) and (b)
California Welfare and Institutions Code Section 14132.3, Medi-Cal managed care plans and administrative days
CDPH AFL 10-21
DHCS Contract, Exhibit A, Attachment 8
DHCS APL 13-005, Requirements for Hospital Administrative Days and Acute Administrative Days
TAR criteria for Acute Administrative Days (AAD) (TAR criteria AAD)
Title 22, California Code of Regulations (CCR), Section 51124, Administrative Days
Title 22, California Code of Regulations, Section 51335, Skilled Nursing Facility Services

Formatted: Space Before: 0 pt, After: 0 pt
Formatted: Space After: 0 pt
Formatted: Space Before: 0 pt

MONITORING

This policy is reviewed annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee/ Utilization Management and Compliance Committee annually for review and approval.

collaboration

Formatted: Font: Not Bold

POLICY AND PROCEDURE

Policy Number	UM-D-001
Policy Name	Prior Authorization/Concurrent Review/Organization Determination Audit Process Policy (RGR)
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	D-SNP
Effective Date	9/17/2025
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Wellness is committed to ensuring compliance with federal and state regulations governing Prior Authorization (PA), Concurrent Review (CR), and Organization Determination (OD) processes. This policy establishes a standardized audit process to evaluate the accuracy to evaluate the accuracy, timeliness, and compliance of these activities, promoting high-quality care and adherence to CMS and DHCS requirements.

This policy applies to all PA, CR, OD processes conducted by the Alliance including internal staff, contracted providers, and delegated entities involved in utilization management.

PROCEDURE

1. Audit Planning
   a. Frequency: Audits are conducted monthly by the Utilization Management Department, Pharmacy Department and/ or Behavioral Health Department with an annual comprehensive review
   b. Audit Team: Composed of licensed nurses, clinical pharmacists, physicians, and compliance officers with expertise in UM and D-SNP regulations
   c. Scope: All PA, CR, and OD processes, including decision timeliness, medical necessity documentation, and adherence to Evidence of Coverage (EOC)
   d. Sample: Random sampling of at least 30 of PA, CR, and/or OD cases monthly, stratified by service types (e.g., inpatient, outpatient, Part B drugs)
2. Audit Execution
   a. Data Collection: Extract data from the clinical documentation systems, and claims databases and verify completeness.

b. Criteria Review: CMS MA regulations, Nationally recognized standards (e.g., MCG, NCDs and LCDs), D-SNP EOC and internal UM policies
c. Timeliness Check: Confirm compliance with standard (7 calendar~~14~~ days for PA/OD, 72 hours for expedited) and CCR timeframes (2 to 5 times per week during inpatient stays).
d. Medical Necessity: Ensure decisions are made by qualified professionals and supported by clinical documentation.
e. Denial Review: Verify that denials (benefit or medical necessity) include clear rationale and appeal rights.

3. Audit Reporting
   a. Documentation of Findings: Audit results are compiled in a report detailing compliance rates, discrepancies, trends.
   b. Corrective Action Plans (CAPs): For non-compliance, CAPs are developed with timelines and responsible parties. CAPs are implemented internally in preparation to share with CMS or DHCS during oversight activities.
   c. Stakeholder Communication: Share findings with UM staff, providers, and delegated entities. Present summary to the Compliance Committee.
   d. Audit results are reported to the D-SNP Utilization Management Committee.

4. Follow-Up:
   a. CAP Monitoring: Track CAP implementation quarterly until resolved.
   b. Re-Audit: Conduct targeted re-audits for areas with significant findings within 90 days.
   c. Continuous Improvement: Incorporate audit findings into UM training and policy updates.

DEFINITIONS

- Prior Authorization (PA): A UM process requiring approval before certain medical services, items, or Part B drugs are provided, ensuring medical necessity and coverage compliance.
- Concurrent Review (CR): UM conducted during an inpatient stay to assess ongoing medical necessity and coordinate care transitions.
- Organization Determination (OD): A decision by the DSNP plan regarding coverage, payment, or provision of medical services, items, or Part B drugs.

AFFECTED DEPARTMENTS/PARTIES

Behavioral Health
Utilization Review

RELATED POLICIES AND PROCEDURES

BH-D-001 Behavioral Health Services, D-SNP

---

draft

REVISION HISTORY

New Policy: 9/17/2025, 4/28/2026

REFERENCES

- Centers for Medicare & Medicaid Services (CMS). (2024). Medicare Advantage Regulations, 42 CFR § 422.101.
- California Code of Regulations, Title 8, Section 9792.6.1. Utilization Review Standards.
- CMS. (2024). Final Rule to Expand Access to Health Information and Improve the Prior Authorization Process.

MONITORING

- ~~Compliance Officer:~~Utilization Management Leadership/ Pharmacy Department Leadership and Behavioral Health Department Leadership ~~O~~oversee~~s~~ audit execution and CAP implementation.
- Quality Management Committee: Reviews audit reports quarterly and approves policy updates.
- External Oversight: Submits audit results to CMS and DHCS during program audits.
- Metrics Tracking: Monitors key performance indicators (KPIs), including:
  - Percentage of authorizations meeting timeliness standards (>95% target).
  - Rate of overturned appeals (<25% target).
  - Documentation completeness (>98% target).

draft

POLICY AND PROCEDURE

Policy Number	UM-029
Policy Name	Sensitive Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	1/1/2008
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

This policy outlines the process and procedure for Sensitive Services including Family Planning, Sterilization, Sexually Transmitted Diseases (STD), HIV Testing and Counseling and Abortion in compliance with the Informed Consent, Minor Consent Services and freedom of choice regulations.

PROCEDURE

1. Informed Consent - Practitioners must furnish Members with sufficient information, in terms that a Member can understand, so that an informed decision can be made.
   a. All Alliance and Out-Of-Network family planning services practitioners must obtain informed consent for all contraceptive methods, including sterilization for members <18 years old. Informed consent is also required in the provision of abortion services. In the event that the Member is unable to give consent, his/her legal guardian must make appropriate care decisions as needed.

2. Freedom of Choice
   a. Members are to be provided with sufficient information to allow them to make informed choices regarding the types of family planning services available, and their right to access these services, including abortion services, in a timely and confidential manner.

3. Medi-Cal, Group Care and D-SNP Members are informed upon enrollment of their right to access family planning services and abortion services within and outside of Alliance's Network, without prior authorization. via the Member Explanation of Coverage Handbook (EOC), Member Newsletter and/ or their Member Services contacts. California Minor Consent
   a. Minors of any age may consent to/receive 'Minor Consent Services' from any Network Provider or Out of Network Provider without a Prior Authorization:

Formatted: Font: (Default) +Body (Calibri)
Formatted: Space Before: 0 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Space Before: 0 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Space Before: 0 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri)
Formatted: Space Before: 0 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)

i. Family Planning services.
ii. Medical care related to the prevention or treatment of pregnancy, except sterilization for members <18 years old.
iii. Birth control.
iv. Abortion.
v. Emergency medical services when parent/guardian unavailable to give consent.
vi. Medical care related to diagnosis, treatment and collection of medical evidence related to a sexual assault.
vii. Medical care related to diagnosis, treatment and collection of medical evidence related to the rape of a minor under age 12.

b. Minors aged 12 and older may consent to/receive:
i. Medical care related to diagnosis, treatment of a sexually transmitted disease (STD).
ii. An HIV test and diagnosis, treatment of HIV/AIDS.
iii. Drug or alcohol abuse
iv. Non-Specialty Mental Health Services, when mature enough to participate in their health care.

4. Family Planning

a. Family planning services are defined as services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Pursuant to State and Federal requirements, Medi-Cal Members have the ability to self- refer, without prior authorization, to a qualified family planning practitioner within the Alliance Network, or self-refer to qualified Out-Of-Network family planning practitioners, also without prior authorization as described in the member's Explanation of Coverage handbook

b. For the Medi-Cal Line of Business tThe following list of services may be provided to Alliance Members as part of the family planning benefit, in or out of network, without prior authorization:
i. Health education and counseling necessary to make informed choices and understand contraceptive methods;
ii. Verbal history and physical examination limited to immediate problem;
iii. Laboratory tests, if medically indicated as part of decision-making process for choice of contraceptive methods;
iv. Follow-up care for complications associated with contraceptive methods issued by the family planning practitioner;
v. Provision of contraceptive pills, devices, supplies;
vi. Provision and insertion of Norplant;
vii. Tubal ligation;
viii. Vasectomies;
ix. Pregnancy testing and counseling;
x. Diagnosis and treatment of STDs if medically indicated (STD diagnosis and treatment, provided during a family planning encounter are considered part of family planning services); and
xi. Screening, testing and counseling of at-risk individuals for HIV (HIV testing and counseling, provided during a family planning encounter, are considered part of family planning services).
xii. Licensed Midwife Services
~~xii.~~

Formatted: Indent: Left: 1.25", No bullets or numbering

c. For the Medi-Cal Line of Business Tthe following list of services are not included within the Family Planning Benefit provided to Alliance Members:
   i. Therapeutic and elective abortions are not considered a part of family planning services.
   ii. Infertility studies, reversal of voluntary sterilization, and hysterectomy for sterilization<18 years old are not included under the Family Planning benefit. For D-SNP some treatments for infertility services may be covered (Not included are artificial ways to become pregnant.)
   ~~ii.~~

Formatted: Font: (Default) +Body (Calibri)

Formatted: Indent: Left: 1.25", No bullets or numbering

d. Accessing Family Planning Services
   i. AAH does not infringe upon any member's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required, including prior authorization, step therapy, or utilization control techniques.
   ii. AAH defers to the determination and judgment of the provider and provides coverage for an alternative prescribed contraceptive drug, device, product, or service without imposing any cost sharing requirements if the covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by the member's provider.
   iii. Out-of-Network family planning practitioners are expected to demonstrate a reasonable effort in coordinating services with Alliance Network practitioners, including educating Members to return to their PCP for continuity and coordination of care.
   iv. Members should be encouraged to approve release of their medical records from the family planning provider to the PCP so that the PCP may coordinate future care accordingly and avoid duplication of already provided services.
   v. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality but allows STD service practitioners adequate information to bill for the services. Practitioners must make such a form available to Members.

e. Coordination of Care - Listed below are the roles and responsibilities of the member's healthcare team. Out-of-Network practitioners should encourage Members to sign release of information forms so that clinical information can be forwarded to the Member's PCP. If a release is signed, and the Member needs care as a follow-up to the family planning services or due to a complication of the family planning service, the Out-Of-Network practitioner must contact the PCP. This applies to Medi-Cal Members only.
   i. The Member's assigned PCP in conjunction with the Alliance is responsible for providing or coordinating any additional health care needed by the Member and/or documenting in the medical record any family planning services received by the Member (e.g., PAP smear, type of birth control method) upon receiving medical records from or being informed by the family planning practitioner or Member.

f. Fertility and Infertility Treatments fFor Alliance Group Care Members
   i. Infertility is defined as a condition or status characterized by any of the following:
      1) A licensed physician's findings, based on the patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and

diagnosis of infertility before the 12-month or 6-month period to establish infertility.

2) A person's inability to reproduce either as an individual or with their partner without medical intervention.

3) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

ii. For Group Care members: AAH contracts ~~that~~ provide coverage for infertility and fertility services from:

~~1) Excluding, limiting, or otherwise restricting coverage of fertility medications that are different from those imposed on other prescription medications.~~

~~2)~~1) Excluding or denying coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party. "Third party" includes an oocyte, sperm, or embryo donor, gestational carrier, or surrogate that enables an intended recipient to become a parent.

~~3) Imposing any deductible, copayment, coinsurance, benefit maximums, waiting period, or any other limitation on coverage for the diagnosis and treatment of infertility that are different than those imposed upon benefits for services not related to infertility.~~

iii. Requires plans, consistent with Section 1365.5, to cover the treatment of infertility and fertility services without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

iv. Alliance shall cover the diagnosis and treatment of infertility and medically necessary fertility services consistent with established medical practices and the most current professional guidelines as published by the American Society for Reproductive Medicine (ASMR) including:

1) Physician services, including consultation and referral
2) Physical examination
3) Genetic evaluation
4) Screening and Diagnostic laboratory and imaging services
5) Semen analysis
6) Tubal evaluation and uterine evaluation
7) Sperm DNA fragmentation analysis
8) Hormone testing
9) Ovulation testing
10) Thyroid function testing
11) Diagnostic surgery and biopsy
12) Any other services to diagnose infertility consistent with ASMR

v. Fertility services to treat infertility as follows:

1) At least three attempts to collect or retrieve sperm
2) At least three completed oocyte retrievals.
3) Procurement of donor semen, oocyte and embryo
4) Physician services, including consultation and referral.

Formatted: Font: (Default) +Body (Calibri), 12 pt, Font color: Custom Color(RGB(36,36,36))

Formatted: Indent: Left: 0.88"

Formatted: Indent: Left: 1.81", Hanging: 0.13", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

5) Surgery to treat infertility
6) Medication to treat infertility
7) Reproductive counseling
8) Genetic counseling
9) Genetic testing and screening
10) Laboratory and imaging services
11) Infectious disease screening and testing
12) Medication to induce ovulation
13) Intrauterine insemination
14) Intracervical insemination
15) Preimplantation genetic testing
16) In vitro maturation
17) In vitro fertilization
18) Intracytoplasmic sperm injection
19) Ovarian tissue reimplantation
20) Embryo biopsy
21) Assisted hatching
22) Thawing of previously cryopreserved gametes, embryos, and tissues
23) Unlimited embryo transfers, using single embryo transfers in accordance with section 1374.55(a)(1)
24) Any other fertility services to treat infertility consistent with the established medical practices and the most current professional guidelines published by ASRM

vii. Donors, Donor Material, and Surrogate services as follows:

1) Laboratory and imaging services
2) Genetic testing and screening
3) Infectious disease screening and testing
4) Medication to induce ovulation
5) Retrieval of donor gametes subject to the limitations specified above.
6) Gamete and embryo transfer
~~iii.~~7) Any other medically necessary infertility and fertility services, as specified above, to enable the enrollee to become a parent using donor gametes, donor embryos, and surrogate services

viii. AAH must cover Cryopreservation and storage of sperm, oocytes, and embryos for a period of at least five years from the time the genetic material is first cryopreserved.

viii. For Surrogacy: If an enrollee is using the services of a surrogate to treat the infertility of the enrollee, in addition to coverage of the above-described services, the enrollee's health plan shall cover medically necessary health testing of the surrogate, as necessary, for each attempt collect eggs or sperm or to create embryos, and for each attempt to achieve a pregnancy with that material. The enrollee's health plan shall not be responsible for health care costs of the surrogate after the embryo transfer procedure, including maternity services, except as required under the terms of the surrogate's health plan contract.

5. Sterilization

a. Pursuant to State and Federal requirements, Medi-Cal Members have the ability to self-

Formatted: Font: (Default) +Body (Calibri)

Formatted: Space Before: 0 pt

Formatted: Font: (Default) +Body (Calibri), 12 pt, Font color: Custom Color(RGB(36,36,36))

Formatted: Indent: Left: 1.75", Hanging: 0.31", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Space Before: 0 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt, Font color: Custom Color(RGB(36,36,36))

Formatted: Indent: Left: 1", No bullets or numbering

Formatted: Indent: Left: 1.75", Hanging: 0.31", Numbered + Level: 4 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt, Font color: Custom Color(RGB(36,36,36))

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Indent: Left: 0.95", Hanging: 0.3"

Formatted: Indent: Left: 0.88", Hanging: 0.31", Tab stops: 1.13", Left + 1.19", Left + Not at 0.88"

Formatted: Font: (Default) +Body (Calibri)

Formatted: Indent: Left: 0.88", First line: 0"

refer, without prior authorization, to a qualified family planning practitioner within the Alliance network or self-refer to qualified out-of-network family planning practitioners, also without prior authorization for sterilization services for members <18 years old (tubal ligation or vasectomy).

b. Practitioners providing sterilization services to members must adhere to informed consent procedures as detailed in Title 22, Section 51305.(1), (2), (3), (4), and outlined below:

   i. Informed consent may not be obtained while the Member is under the influence of alcohol, or any substance that affects the Members state of awareness.

   ii. Consent may not be obtained while the Member is in labor, within 24 hours of delivery, post abortion, or if the Member is seeking to obtain or obtaining an abortion.

   iii. Written informed consent must have been given at least 30 days and no more than 180 days before the procedure is performed.

      1). A copy of the consent form and the booklet on sterilization published by the Department of Healthcare Services (DHCS) must be given to the Member.

   iv. A hysterectomy requires an additional consent form. A hysterectomy is not compensated under the Medi-Cal program if performed or arranged for the sole purpose of rendering the Member sterile.

   v. Sterilization may be performed at the time of emergency abdominal surgery or premature delivery if the Member consented to sterilization at least 30 days prior to the intended date of sterilization or the expected date of delivery or at least 72 hours have passed between the time that written consent was given and the time of the emergency surgery or premature delivery. The consent must also have been signed 72 hours prior to the Member having received any preoperative medication.

   vi. The PM 330 Consent Form must be fully completed at the time of the procedure.

   vii. Original copies of the informed consent are filed in the Member's medical record.

Formatted: Space Before: 0 pt

c. Access to Sterilization Services

   a. For Medi-Cal Members:

      1). The Medi-Cal Member may select a qualified family planning practitioner of his/her choice within the Alliance network, or out of network.

      2). Out-of-network family planning practitioners are expected to demonstrate a reasonable effort in coordinating services with Alliance network practitioners, including educating Members to return to their PCP for continuity and quality of care.

   b. For D-SNP Members:

   Under the D-SNP Program Guidelines the coverage of sterilization is limited to treatment of an illness or injury. Services that are not covered in the absence of medical necessity are elective hysterectomies, tubal ligation and vasectomies.

   A nonemergency hysterectomy may be covered only if:

   1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile,

   2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and

   3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician

certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.

6. Sexually Transmitted Diseases

Formatted: Space Before: 0 pt

a. PCPs are required to follow the latest STD treatment guidelines recommended by the U.S. Public Health Service (USPHS) as published in the Mortality and Morbidity Weekly Report (MMWR).

b. All Medi-Cal Members have the right to seek treatment for sexually transmitted diseases from their PCP, the Local Health Department (LHD) county clinics, qualified family planning practitioners, or any other practitioner who treats STDs within his or her scope of practice. Services may be obtained from a practitioner in or outside of the Alliance Network, without prior authorization.

c. Members age 12 years and older, may access STD services from practitioners noted above without parental consent, and without prior authorization.

d. Pursuant to California Health and Safety Code Section 120582, licensed physicians, nurse practitioners, certified nurse-midwives, or physician assistants who are practicing within their authorized scope of practice may prescribe, dispense, furnish, or otherwise provide prescription antibiotic medications to the sexual partner or partners of a Member with a diagnosed sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, without examination of the Member's sexual partner or partners.
   a. Access Within Network
      i. Medi-Cal Members may elect to receive STD services from their PCPs or qualified practitioners within the Alliance Network.
      ii. PCPs are required to offer all Members appropriate STD services, including screening, counseling, education, diagnosis and treatment.
   b. Confidentiality and Reporting
      i. The expressed, written consent of the Member or legal representative is required for the release of medical records to another party outside of the practitioner. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality but gives STD services practitioners adequate information for billing purposes. Practitioners must make such a form available to their Members.
      ii. All practitioners providing STD services are required by law to report individuals with certain communicable diseases to the Local Health Department (LHD).
      iii. Medical records for Members presenting for STD evaluation must be maintained to protect the confidentiality of the Member. In-network practitioners must adhere to Alliance Medical Records policies and procedures.
   c. Access Out-of-Network
      i. An Out-Of-Network practitioner may be a family planning practitioner, an LHD, or any other practitioner who provides STD services within their scope of licensure and practice. Members may access STD services through Out-Of-Network practitioners without prior authorization.

ii. Medi-Cal Members may make their own appointment with the STD services practitioner of their choice. Members should return to their PCPs to maintain continuity of care.

iii. STD services provided through Out-Of-Network practitioners must be reimbursed at the Medi-Cal fee-for-service (FFS) rate, unless otherwise negotiated in subcontracts with the Alliance.

d. Coordination of Care

PCPs are responsible for coordination of care and avoiding duplicate delivery of services for those Members who inform them and/or release medical records for Out-Of-Network STD treatment received.

i. The reimbursement for Out-Of-Network practitioners not associated with an LHD for STD services is limited to one office visit per disease episode for:

1) Diagnosis and treatment of vaginal discharge and urethral discharge.
2) Evaluation and initiation of treatment of Pelvic Inflammatory Disease (PID)
3) Those STDs that are responsive to immediate diagnosis and treatment:
4) Bacterial vaginosis
5) Candidiasis
6) Chancroid
7) Chlamydia
8) Gonorrhea
9) Granuloma inguinale
10) Herpes simplex
11) Human papilloma virus
12) Lymphogranuloma venereum
13) Non-gonococcal urethritis
14) Syphilis
15) Trichomoniasis

ii. Practitioners providing STD services who wish to register a grievance regarding non-payment, underpayment, or any billing related issue.

7. HIV Testing and Counseling

a. PCPs are required to assess all Alliance Members for risk factors for HIV infection. Those Members determined to be at risk must be offered HIV testing and counseling by their PCP, or be referred to a LHD operated or contracted anonymous HIV testing site.

b. Medi-Cal Members can access HIV testing and counseling as part of a family planning or STD visit, or at a LHD operated or contracted HIV testing site, without prior authorization regardless of the provider's contracting status with the Alliance.

c. Alliance Providers are required to follow all State laws governing consent for testing and disclosure of HIV test results, as well as the latest "HIV Counseling, Testing, and Referral Standards and Guidelines" recommended by the U.S. Public Health Service (Guidelines may be found via the internet at www.cdcnpin.org).

d. Access to HIV Counseling and Testing Services Overview

i. PCPs are required to assess Members for risk factors for HIV infection. The assessment can occur in the following situations:

1). As part of a well-child or adult physical exam.
2). At the time of a visit for illness or injury.
3). At the request of a Member, Member's parent or guardian.

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Draft

4). Other appropriate circumstances.

ii. The assessment by the PCP should include the following:
   1). Obtaining a sexual history in sufficient detail to assess risk.
   2). Discussing any history of substance abuse including use of needles.
   3). History of significant blood transfusions in the past during period of infected blood supply.
   4). If a newborn or young child, the history above for mother of the child.
   5). Assessment for otherwise unexplained generalized signs and symptoms, or laboratory results suggestive of a chronic process with underlying immune deficiency

iii. Assessment for signs and symptoms of acute retroviral syndrome For those Members identified by the PCP as at risk for HIV infection, one of the following must occur:
   1). PCP provides HIV testing and counseling.
   2). For Medi-Cal Members, either the PCP refers the Member, or the Member can self-refer to a LHD operated or contracted HIV testing and counseling site for confidential or anonymous services.

iv. Alliance Member Services is available to assist Members requesting access to HIV testing and counseling services by informing them of their options described above and/or referring them to LHD operated or contracted sites.

v. PCPs and specialists caring for Members who are children must offer HIV counseling to parents or legal guardians and education, counseling and testing where appropriate to infants, children and adolescents in the following categories:
   1). Infants and children of HIV seropositive mothers.
   2). Infants and children of mothers at high risk for HIV infection with unknown HIV serologic status including:
      a). Children born with a positive drug screen;
      b). Children born to mothers who admit to present or past use of illicit drugs;
      c). Children born with symptoms of drug withdrawal;
      d). Children born to mothers who have arrests for drug-related offenses or prostitution;
      e). Children born to mothers with any male partners at high risk for HIV,and
      f). Any abandoned newborn infants.
   3). Sexually abused children and adolescents.
   4). Children receiving blood transfusion/blood products between 1977-1985 or symptomatic children receiving transfusions since 1985.
   5). Adolescents who engage in high risk behaviors including unprotected sexual activity, illicit drug use, or who have had STDs.
   6). Other children deemed at high risk by a practitioner.

e. HIV Testing, Counseling and Follow-up for Prenatal Women
   i. Alliance network practitioners who provide women's health care services must comply with current law (California Health and Safety Code, Section 125107) that requires the health care professional primarily responsible for providing prenatal care to a pregnant Member to offer HIV information and counseling to every pregnant Member, including, but not limited to:
      1). Mode of transmission
      2). Risk reduction and behavior modification including methods to

draft

reduce the risk of perinatal transmission.

3). Referral to other HIV prevention and psychosocial services

ii. The Alliance requires that all prenatal care practitioners offer HIV testing to every pregnant Member, unless the Member has a positive test result documented in the medical record or has AIDS as diagnosed by a practitioner.

iii. All Alliance prenatal care practitioners are required to discuss with the Member:

1). The purpose of the test.

2). Its potential risks and benefits, including treatment to reduce transmission to the newborn and that it is a voluntary test.

iv. Practitioners must document in the Member's medical record that education, counseling and testing was offered to the pregnant Member.

f. Out-of-Network Reimbursement for Medi-Cal Members

i. HIV testing and counseling services provided through LHDs, sites subcontracted by LHDs or qualified family planning practitioners as part of a family planning visit must be reimbursed at the Medi-Cal fee-for-service rate, unless otherwise negotiated by the Alliance.

ii. Out-of-network practitioners must provide proof of service adequate for audit purposes.

iii. All out-of-network practitioner HIV testing and counseling claims grievances are resolved per the Alliance Provider Grievance Process (see Policy G&A-009 "Provider Grievances"").

iv. Also included for the D-SNP LOB: Pharmacists in a community pharmacy setting furnishing specified categories of drugs including HIV pre-exposure and post-exposure prophylaxis and initiating and administrating is a covered benefit under the D-SNP LOB. All documentation in Member's charts and release of information regarding HIV tests must conform to all provisions of California Health and Safety Code Division 105, Part 4, including Sections 120975, 120980, 120985, and 121010, 199.25, and Insurance Code Section 791.06. Confidentiality guidelines are set below:

1). The practitioner ordering the test may record the results in the subject's medical record and disclose the results to other practitioners for purposes of diagnosis, care or treatment without written authorization of the subject.

2). The practitioner ordering the test may NOT disclose the results of the test to Alliance or any other health care service plan.

3). All records reflecting HIV testing must be kept in a locked cabinet accessible only by authorized personnel.

g. Consent of HIV Testing and Disclosure of HIV Test Results

i. All practitioners ordering HIV tests must either obtain written consent or informed verbal consent from the Member. Informed verbal consent is only sufficient when a treating practitioner orders the test.

ii. Except in cases where direct health care practitioners are disclosing the results of an HIV test for purposes directly related to the health care of the Member, all Alliance network practitioners must obtain written consent from the Member to disclose results of an HIV test.

h. Reporting

i. All practitioners are required to comply with state law and report all known AIDS cases to the LHD. (See UM-023 Communicable Disease Reporting and Services).

Formatted: Font: (Default) +Body (Calibri)

8. Abortion Services

a. The Reproductive Privacy Act provides that the state and therefore the Alliance as a contractor, may not deny or interfere with a person's right to choose or obtain an abortion prior to viability of the fetus or when an abortion is necessary to protect the life or health of the pregnant individual.

b. Abortion services are a covered physician service and a sensitive service. Abortion is a covered benefit regardless of the gestational age of the fetus. All medical services and supplies incidental or preliminary to an abortion as defined in the DHCS Provider Manual will be covered. The Alliance and its delegates will maintain procedures that ensure confidentiality and timely access to these sensitive services. When necessary, the Alliance will help find the member find a Provider for these services.

c. In order to access abortion services, Medi-Cal Members have the ability to self-refer, without prior authorization or medical justification, to a qualified practitioner within or outside of the Alliance Network, when performed in an outpatient setting. The Alliance will not impose any utilization management or utilization review requirements on coverage of outpatient abortion services. The Alliance will not impose any annual or lifetime limits on the coverage of outpatient abortion services. Deductibles, coinsurance, copayments or any other cost-sharing requirements for an abortion or abortion-related services is prohibited and not required.

d. Minors who wish to receive abortion services may do so without parental consent under the Medi-Cal Minor Consent Program.

e. The Alliance will notify members when they enroll with the Alliance that some providers, hospitals, and clinics do not perform abortion services, and that the Alliance will assist the member to obtain the services from a provider, hospital or clinic who will provide the service. The Alliance will ensure that members have timely access to abortion services.

   i. Abortion services, the medical services and supplies incidental or preliminary to an abortion, which are consistent with the requirements outlined in the MediCal Provider Manual.

   ii. All outpatient abortion services do not require prior authorization or annual or lifetime limits. The Alliance will not apply any utilization review requirements or utilization management on the coverage of outpatient abortion services.

   iii. Non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization under the same criteria as other medical procedures (see California Code of Regulations [CCR],Title 22, Section 51327).

   iv. Line of Business: Group Care members can access abortion services without a referral or prior authorization; however, these services are not covered if performed by an Out-Of- Network practitioner.

f. Accessing Abortion Services

   i. Medi-Cal Members can go to any Medi-Cal provider of their choice for abortion services, at any time for any reason, regardless of the network affiliation. The Alliance will ensure members have timely access to abortion services.

      1) The Alliance or its delegates will not require a Physician, health care provider or person to participate in performance of abortion services. No person or provider who refuses to perform abortion services will be subject to penalty or discipline in any form for such a choice.

   ii. Will inform members when they enroll that some hospitals, clinics, and other

Providers in their Network may refuse to provide abortion services. In such case, the Alliance must help the member find another provider for the needed services.

g. Consent to Abortion Services
   i. Minor consent – refer to the MediCal Minor Consent Program and CMP-015 Minor Consent to Medical Care
h. Prohibition Against Interfering with Abortion Services
   i. The Reproductive Privacy Act (Health and Safety Code Section 123460, et seq.) provides that California, and plans as contractors, may not deny or interfere with a women's right to choose or obtain an abortion prior to viability of the fetus or when an abortion is necessary to protect the life or health of the pregnant individual.

F. 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-400~~019~~ for monitoring of delegation oversight.

DEFINITIONS / ACRONYMS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CLM-010 Family Planning & Sensitive Services Claims Processing
CLM-011 Abortion Services Claims Processing
CMP-015~~210~~ Minor Consent to Medical Care
CMP- 400 Delegation Oversight
UM-023 Communicable Disease Reporting and Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

1/1/2008, 1/16/2009, 9/6/2012. 4/21/2014, 10/14/2015, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 7/17/2024, 09/17/2025, 4/29/2026

REFERENCES

Formatted: Space Before: 0 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt

1. All Plan Letter 24-003
2. Boilerplate 2025 SMAC EAE D-SNP
3. California Family Code Sections 6925-6928
4. DHCS Contract Exhibit A, Attachment 9, Provision 9 2.
5. DMHC APL 25-021 Infertility and fertility services
6. Health Care Coverage: Abortion Services: cost sharing, SB 245, (Chapter 11, Statutes of 2022), 2021-2022 Session, (2022)
7. Health and Safety Code section 1234.20, 1374.55
8. Reproductive Privacy Act
8. Senate Bill 245 (Chapter 11, Statutes of 2022)
9. Senate Bill 729: Health Care Coverage: Treatment for Infertility and Fertility Services
10. The Medi-Cal Provider Manual for the Minor Consent Program
11. Title 22, California Code of Regulations (CCR), Section 51327
12. Title 22, Section 51305.(1), (2), (3), (4)

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/ Utilization Management Committee and Administrative Oversight Committee.

Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri), 12 pt
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri)
Formatted: Font: (Default) +Body (Calibri), 12 pt

draft