ALAMEDA Alliance FOR HEALTH

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

Quality Improvement Health Equity Committee Voting Items Policies & Procedures May 9, 2025

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

Policy Procedures Summary of Changes

Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update (X)	New Policy (X)	Annual Review or Formatting Changes (X)	Retire (X)	Presenter
CS	CS-001	Community Supports – Oversight, Monitoring & Controls	This policy outlines the process in which Alameda Alliance for Health (AAH) will oversee its contracted providers who deliver Community Supports (CS) services.	Added D-SNP, Formatting changes, content updated	X				Kimberly Glasby
CS	CS-005	Community Supports – Asthma Remediation	This policy outlines the process in which Alameda Alliance for Health processes the Asthma Remediation Community Support.	Added D-SNP, Formatting changes, content updated with APS program requirements, Added closed loop referral statement, updates APL	X				Kimberly Glasby
CS	CS-006	Community Supports – Recuperative Care (Medical Respite)	This policy outlines the process in which Alameda Alliance for Health processes the Recuperative Care/Medical Respite Community Support.	Added D-SNP, Formatting changes, content updated, Added closed loop referral statement, updates APL	X				Kimberly Glasby
Quality	QI -114	Monitoring of Access and Availability Standards	Describes how the Alliance has established a mechanism for ongoing monitoring of its provider network to ensure timely access to and availability of quality health care services for all members within the Alliance and delegate network.	Updated policy to include types of high volume BH providers (Psychologists, LCSWs, Licensed Marriage & Family Therapist), in accordance with NCQA standard NET 1, Element D, factor 1.	X				Loc Tran
Quality	QI-133	Inter-Rater Reliability (IRR) -Testing for Clinical Decision Making	Describes monitoring process for consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring	1) Added MCARE/DSNP 2) Modified HCQC to QIHEC 3) Incorporated BH IRR 4) Added language related to Milliman Care Guidelines as part of IRR 5) Modified scoring and actions, including attempts, testing, and oversight	X				Michelle Stott
Member Services	MBR -024	Exempt Grievance	Describes procedures for the submittal, processing, and resolution of Exempt Grievances	Minor grammar edits.			x		Gia DeGrano

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

POLICY AND PROCEDURE

Policy Number	CS-001
Policy Name	Community Supports – Oversight, Monitoring & Controls
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, ~~Social Determinants of Health~~Long Term Services and Supports
Line(s) of Business	DSNP, MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/21/2020~~4TBD
Administrative Oversight Committee Approval Date	~~9/18/2024~~TBD

POLICY STATEMENT

This policy outlines the process in which Alameda Alliance for Health (AAH) will oversee its contracted providers who deliver Community Supports (CS) services.

Community Supports are optional services that can be offered by AAH when deemed medically appropriate and cost-effective substitutes for covered services.

PROCEDURE

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

I. Provider Expectations

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

Formatted: Indent: Left: 0.31"

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.75" + Indent at: 1"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 2 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

~~1.2.1.~~b. Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

~~1.3.~~c. AAH takes a proactive approach to ensuring authorization for CS in a medically appropriate, equitable, and non-discriminatory manner. Each interested CS provider is required to go through a pre-certification process. The pre-certification includes requesting proof of culturally-competent and linguistically-appropriate services. AAH seeks to contract with a diverse set of providers to ensure non-discrimination, specifically in the area of diverse language capacity. AAH also employs a culturally diverse staff. Once a provider has been contracted, training is provided which has cultural sensitivity practices built in. Also, non-discriminatory practices are inherent to the annual Population Needs Assessment and Population Health Management Strategy, both of which are drivers in the selection process for bringing on new CS services.

~~1.4.~~d. AAH monitors and evaluates the effectiveness and cost-effectiveness of the CS services.

~~PROCEDURE~~

~~2.1~~II. Auditing and Oversight of CS Provider Activities

~~2.1.1~~**a)** AAH will conduct auditing and oversight of CS Provider activities through the following:

- Monthly monitoring of CS and reports;

~~b)~~• Quarterly monitoring of AAH internal and regulatory reports; and

~~c)~~• Annual CS Provider onsite visits and case file review appropriate to the category of CS. These visits may be done remotely, as necessary.

~~2.2~~**b)** CS Data and Reports

~~2.2.1~~**1)** AAH will collect and monitor CS services utilizing operational and clinical data, including data submitted from CS Providers as well as internal data.

~~2.2.2~~**2)** Data submitted from CS Providers will be monitored for completeness and data accuracy to meet all reporting requirements set forth by AAH and DHCS.

~~2.2.3~~**3)** AAH Analytics team will develop CS reports that will include utilization by approved, denied, and received services as well as by other categories such as CS service and provider. Additional reporting may include financial, Grievance and Appeals, and other utilization and quality metric reports.

~~2.2.4~~**4)** In addition, AAH will produce and monitor all regulatory reporting as required by DHCS.

Formatted: Font: 12 pt

Formatted: Numbered + Level: 2 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.75" + Indent at: 1"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

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

Formatted: Font: 12 pt

Formatted: Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 2 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 1" + Indent at: 1.25"

~~2.2.5~~**5)** Reports will be produced on a monthly and/or quarterly basis and distributed to the appropriate teams for monitoring and review.

~~2.2.6~~III. Analysis of effectiveness and cost-effectiveness of CS Services

~~b)~~ a) Pre-approved CS services have been deemed cost-effective alternatives to State Plan Covered services or settings by DHCS~~, taking into consideration the results of the Whole Person Care (WPC) and Health Homes Pilot (HHP).~~

~~c)~~b) AAH will perform annual analysis of CS members to evaluate whether a CS is a cost-effective alternative to a State Plan Covered service or setting. Financial and utilization analysis of members receiving CS will be included. Industry standard metrics will be used to analyze utilization patterns and trends across care settings as well as total costs for the CS population.

~~d)~~c) Diversity and equity utilization metrics will be analyzed and compared against AAH's overall population. The outcomes of these analyses will provide information as to whether any modifications should be made to the CS service offering. Appropriate lag times will be incorporated as necessary. Should evaluation findings identify instances where service authorizations have had an inequitable effect, a special task force, including the provider, will be convened to identify the root cause. Interventions would include re-training, enhanced outreach and network development, as needed, to focus on quality initiatives.

~~2.2.7~~d) AAH's CS, Analytics and Quality teams utilize information obtained and incorporate CS data into Plan Quality Activities. AAH staff will utilize information obtained to define and drive improvement through interventions and education with targeted providers who have unique or outlying issues or identified trends.

~~2.3~~IV. ~~–~~CS Provider Onsite Visits and Case File Reviews

~~2.3.1~~a) AAH CS Staff perform site visits, when possible, in order to evaluate CS operational and care management activities.

b) Year 1: AAH staff will perform onsite (when possible) visits at least once during the first year and more frequently if issues are identified through the quarterly reports of CS Provider activities.

c) Year 2 and beyond: AAH staff will perform onsite (when possible) visits annually in order to assess CS activities. Onsite visits will assess both operational and care management activities of the CS Providers.

d) Operational areas to be reviewed include:

- Staffing, including Case Ratios as applicable
- Reporting and tracking systems
- Program development
- Staff training

~~2.3.2~~e) Case File Review: A random sample of cases , using 8/30 methodology will be

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.75" + Indent at: 1"

Formatted: Font: 12 pt

Formatted: Normal, Indent: Left: 0.5", Right: 0.63", Space Before: 6 pt, Line spacing: Multiple 1.06 li, No bullets or numbering

Formatted: Indent: Left: 0.5", Hanging: 0.25"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 4 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 0.75" + Indent at: 1"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 2 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Outline numbered + Level: 4 + Numbering Style: a, b, c, … + Start at: 3 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 4 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 4 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

reviewed for evidence of required CS Care Management services including:

- ~~b)~~• Outreach and engagement
- ~~c)~~• Communication between CS Care Team members and Primary Care provider
- ~~d)~~• Process metrics specific to the category of CS being provided to assess compliance with regulatory, contractual and programmatic requirements.
- ~~e)~~• Incorporation of Trauma Informed Care practices

~~2.3.3~~f) AAH will work collaboratively with CS Providers in order to identify and address solutions and resolve any areas of deficiency.

~~2.3.4~~g) If a corrective approach to deficiency cannot be agreed upon, then a formal CAP may be required.

~~2.3.5~~h) If a CAP is requested and the CS Provider does not meet or is unable to meet the CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to ensure that the CS Provider is meeting CS program delivery requirements.

Formatted: Bulleted + Level: 1 + Aligned at: 1" + Indent at: 1.25"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 6 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 7 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 8 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

DEFINITIONS / ACRONYMS

CS	Community Supports
AAH	Alameda Alliance for Health
DHCS	Department of Health Care Services
CAP	Corrective Action Plan
HEDIS	Healthcare Effectiveness Data and Information Set

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Credentialing

RELATED POLICIES AND PROCEDURES

CRE-018 Credentialing and Recredentialing of Community Supports Providers

REVISION HISTORY

01/11/2023, 3/19/2024, 9/18/2024, 04/01/25

REFERENCES

~~CM~~CS-~~027~~ 001 Community Supports – Oversight, Monitoring, & Controls

MONITORING

~~Monthly schedule~~A Schedule will be established and shared with CS providers ~~at the beginning of each year for scheduled~~for CS Provider oversight & monitoring.

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

POLICY AND PROCEDURE

Policy Number	CS-005
Policy Name	Community Supports – Asthma Remediation
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, ~~Social Determinants of Health~~Long Term Services and Supports
Line(s) of Business	D-SNP, Medi-Cal
Effective Date	01/01/2022
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

This policy outlines the process in which Alameda Alliance for Health processes the Asthma Remediation Community Support.

Environmental asthma trigger remediations consist of physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

Services that are covered by the Asthma Remediation Community support include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) mechanical filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;

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

Formatted: Font color: Black

Formatted: List Paragraph, Space Before: 0 pt, Bulleted + Level: 1 + Aligned at: 1" + Indent at: 1.25", Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

Formatted: Font color: Black

- Mechanical Air filters/Air Cleaners;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate for the management and treatment of Asthma

PROCEDURE

I. Asthma Preventive Services (APS)

a. An in-home environmental trigger assessment will be conducted by an Asthma Preventative Service (APS) provider through the DHCS APS benefit.

   i. In-home environmental trigger assessments are defined as the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants. This assessment guides the supplies, home modifications, and asthma self-management education about actions to mitigate or control environmental exposures offered to the Member.

b. Any need for continued self-management and education will also be provided through an APS provider through the DHCS APS benefit.

   i. Asthma self-management education can include, but is not limited to:

      1. Teaching members hoe to manage their asthma, including how to use inhalers;
      2. Teaching Members how to identify environmental triggers commonly found in their own home, including allergens and irritants; and
      3. Informing Members about various options for reducing environmental triggers such as using dust-proof mattresses and pillow covers, asthma-friendly cleaning products, air filters, etc.

II. Eligibility

a. During the timeframe of 01/01/25-12/31/25: Members identified via analytic reports who have poorly controlled asthma as defined by:

Formatted: Font color: Black

Formatted: List Paragraph, Indent: Left: 1.25", Space Before: 0 pt, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted

Formatted: Font: Bold

i. Emergency Department visit in the past 12 months, or

ii. Hospitalization on the past 12 months, or

iii. Two sick or Urgent Care visits in the past 12 months, or

iv. A score of 19 or lower on the Asthma Control Test, or

v. A recommendation from a licensed health care provider that the service will likely avoid asthma-related hospitalizations, emergency department visits, and/or other high-cost services

b. Starting 01/01/2026: Members who have had completes on-home environmental trigger assessment within the last 12 months through APS, that has identified medically appropriate Asthma Remediations and specifies of the interventions meet the needs of the member.

c. If another State Plan service beyond the APS, such as Durable Medical Equipment (DME), is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, the State Plan services should be accessed first.

d. All asthma remediations should be conducted in accordance with applicable State and local building codes.

e. Asthma remediations are payable up to a total lifetime maximum of $7500.

i. An exception can be made to the $7500 if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid initialization or hospitalization.

~~1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.~~

~~1.2 AAH works with community resources to ensure access to and delivery of CS services.~~

~~1.3 Through oversight and auditing AAH ensures that CS Providers are providing CS Asthma Remediation Services to their CS clients.~~

~~1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.~~

~~1.4 Environmental asthma trigger remediations consist of physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.~~

~~1.5 Examples of environmental asthma trigger remediations include:~~

Formatted

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted

Formatted: Font: Not Bold

Formatted: Normal, Left, Indent: Left: 1.5"

Formatted: Character scale: 100%

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

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;

1.6 The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

1.7 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.7.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.7.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.7.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

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

PROCEDURE

2.1 AAH's Asthma Remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediation designed to avoid asthma-related hospitalizations such as:

2.1.1 Identification of environmental triggers commonly found in and around the home, including allergens and irritants;

2.1.2 Using dust-proof mattress and pillow covers, high-efficiency particulate air

~~vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters; and~~

~~2.1.3 Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.~~

III. Referrals

a. Referrals to the Asthma Remediation Community support can be received from:

i. The member themselves

ii. A members representative

iii. A Members Provider

iv. Other internal departments at the Alliance

v. Through Analytic data ran by the Alliance

b. For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.

c. Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1– 888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

IV. Review

a) When the Alliance receives a request for Asthma remediation, they will review the documentation submitted by the provider. This will include the following:

1. Request from the Asthma Remediation provider
2. Prior to 01/01/26:
    a. A healthcare provider's order specifying the requested remediation(s)
    b. Documentation from the provider describing how the remediation(s) meet the medical needs of the Member, including an evaluation describing how the remediation(s) will meet the needs of the Member.
    c. A home visit assessment to assess that the remediation(s) are suitable for the current living space.

Formatted: Font: Bold
Formatted: Font: Bold
Formatted: Font: Bold
Formatted: Font: Bold
Formatted: Font: Bold
Formatted: Font: Bold
Formatted: Font: Bold
Formatted: Font: 12 pt
Formatted: Space Before: 6 pt, After: 0 pt, Numbered + Level: 2 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.5" + Indent at: 1.75", Tab stops: Not at 5.94" + 6.19"
Formatted: Font: 12 pt, Bold
Formatted: Font: Bold
Formatted: Indent: Left: 1.75", No bullets or numbering
Formatted: Font: Not Bold
Formatted: Font: Not Bold

3. After 01/01/26:

a. A completed in home assessment performed in the last 12 months through the APS benefit

b. The APS recommendations of the needed interventions based on their assessment

b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.

c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.

d) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

V. Closed Loop Referral

a. All referral and authorization requests will be tracked through the required DHCS closed loop referral process.

Formatted: Font: Not Bold

Formatted

Formatted: Normal, No bullets or numbering

~~2.2 When authorizing asthma remediation as a CS, AAH must receive and document the following from the CS Provider:~~

~~2.2.1 The participant's current licensed health care provider's order specifying the requested remediation(s);~~

~~2.2.2 Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary;~~

~~2.2.3 That a home visit has been conducted to determine the suitability of any requested remediation(s). Home visits may be temporarily suspended during a declared health emergency, however, alternative means of communication with member should be employed to contact member during this time.~~

~~2.3 Member Identification.~~

~~2.3.1 Referral Based CS~~

~~2.3.1.1 Monthly, the Analytics department runs a Population Report, using medical and pharmacy data for all members using the specific Asthma Remediation criteria to identify members.~~

2.3.1.2 The Population Report is provided to the Community Supports (CS) department monthly for further processing.

2.3.1.3 Notification of Eligibility

Members are notified of Asthma Remediation eligibility via written communication.

If no address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all progress in the system of record.

2.4 Referral Based CS

2.4.1.1 Assignment to a CS Provider will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location

2.4.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's caregiver/family, guardian, or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible, will then connect the Member to a CS Provider for the provision of services.

2.4.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.4.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.5 Eligibility: Individuals with poorly controlled asthma (as determined by an emergency department visit, hospitalization, or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

2.6 Continuity of Care

2.6.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.6.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the

Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.6.2.1 AAH offers the CS service which the member received through their prior MCP.

2.6.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.

2.6.3 AAH will automatically authorize the CS service when the above conditions are met.

2.7 Member Request for Asthma Remediation Services

2.7.1 AAH verifies a member's health plan

2.7.1.1 Request is reviewed

2.7.1.2 Approval/Denial determination is made per UM Policy, UM-057, process

2.7.1.3 Member and provider notified in accordance with UM Policy, UM-057, Authorization Service Request

2.7.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.7.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.7.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.7.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.7.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.7.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

~~2.8~~VI. Data Sharing

~~2.8.1~~a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

~~2.8.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.~~

~~2.8.3~~b) AAH and CS Provider accesses available data exchange platform(s) when possible.

~~2.8.4~~c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

~~2.8.5~~d) AAH collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

~~2.9 Payment~~

~~2.9.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~

~~2.9.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:~~

~~2.9.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~

~~2.9.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~

~~2.9.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~

~~2.9.3 PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.10~~VII. Restrictions and Limitations

Formatted: Font: Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Right + Aligned at: 1" + Indent at: 1.25"

Formatted: Space Before: 6 pt, Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.5" + Indent at: 1.75"

Formatted: Space Before: 6 pt, Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.5" + Indent at: 1.75"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.5" + Indent at: 1.75"

Formatted: Font: Bold

Formatted: Space Before: 6 pt, Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 7 + Alignment: Right + Aligned at: 1" + Indent at: 1.25"

a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered if:

1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service,

~~2.10.1~~ 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports are authorized and identified in the AAH managed care plan contract.

~~2.10.1.1~~b) AAH will not use the Asthma Remediation CS if another State Plan service, such as Durable Medical Equipment (DME), is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

~~2.10.1.2~~c) Asthma remediations must be conducted in accordance with applicable State and local building codes.

~~2.10.1.3~~d) AAH will ensure individuals will not receive duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

~~2.10.1.4~~e) Asthma Remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

~~2.10.1.5~~f)Asthma Remediation modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

~~2.10.1.6~~g) Before commencement of a physical adaptation to the home or installation of equipment in the home, AAH will provide the owner and beneficiary with written documentation that the modifications are permanent, and that ~~the State~~AAH is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

~~2.10.2~~h) AAH currently contracts with a provider who provides Asthma Remediation services and expects to re-contract with this provider as a CS Provider. AAH expanded Asthma Remediation services to adults through the current provider and through other interested and qualified providers. AAH will continue to evaluate provider capacity and network expansion as necessary.

~~2.11~~VIII. Discontinuing Services

~~2.11.1~~a) Discontinuing of CS services will be based on:

~~2.11.1.1~~• -Goals met/improved health status

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

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1" + Indent at: 1.25"

Formatted: Font: Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 8 + Alignment: Right + Aligned at: 0.69" + Indent at: 0.94"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Bulleted + Level: 1 + Aligned at: 1.5" + Indent at: 1.75"

~~2.11.1.2~~• ~~-~~Termination of coverage

~~2.11.1.3~~• ~~-~~Unable to establish or maintain contact with a member

~~2.11.1.4~~• ~~-~~No longer meets criteria

~~2.11.1.5~~• ~~-~~Member/caregiver declines services

~~2.11.1.6~~• ~~-~~Death of member

~~2.11.2 CS provider will submit monthly reports identifying AAH members who have completed the CS service.~~

~~2.11.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.~~

~~2.12~~**IX. Licensing / Allowable Providers**

~~2.12.1~~a) AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for asthma self-management education.

~~2.12.2~~b) CS Providers must have experience and expertise with providing these unique services.

~~2.12.3~~c) Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

~~2.12.4~~d) AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above

~~2.12.4.1~~e) CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained

~~2.12.5~~f) AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

~~2.12.6~~g) The AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL ~~19-004~~22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

Formatted: Bulleted + Level: 1 + Aligned at: 1.5" + Indent at: 1.75"

Formatted: Font: Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 9 + Alignment: Right + Aligned at: 0.75" + Indent at: 1"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"

DEFINITIONS / ACRONYMS

CS	Community Supports
CB-CME	Community Based Care Management Entity
HCSA	Health Care Services Agency

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CRE-018 Assessment of Community Supports Organizational Providers
UM-036 Continuity of Care
CS-014 Non-Housing Community Supports Criteria

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/28/2022, 01/11/2023, 3/19/2024, 9/18/2024, 04/01/2025

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx
DHCS APL 22-013 Credentialing/Recredentialing and Screening/Enrollment

MONITORING

CSM-027-001 Community Supports – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	CS-006
Policy Name	Community Supports – Recuperative Care (Medical Respite)
Department Name	Community Supports Division
Department Officer	Chief Medical Officer
Policy Owner	Director, ~~Social Determinants of Health~~Long-Term Services and Supports
Line(s) of Business	D-SNP, MCAL
Effective Date	01/01/2022
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

This policy outlines the process in which Alameda Alliance for Health processes the Recuperative Care/Medical Respite Community Support.

Recuperative Care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.
At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

- Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
- Coordination of transportation to post-discharge appointments

Formatted: Font: (Default) Times New Roman

Formatted: Font: 12 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Font: (Default) Times New Roman

Formatted: Indent: Left: 0.75"

Formatted: Font: 12 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

- Connection to any other on-going services an individual may require including mental health and substance use disorder services
- Support in accessing benefits and housing
- Gaining stability with case management relationships and programs

~~1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.~~

~~1.2 AAH works with community resources to ensure access to and delivery of CS services.~~

~~1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Recuperative Care (Medical Respite) Services for their CS clients experiencing homelessness and housing instability.~~

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

~~1.4 Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.~~

~~1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.~~

- ~~AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.~~
- ~~The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.~~
- ~~The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.~~
- ~~Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with~~

Formatted: Font: (Default) Times New Roman

Formatted: Indent: Left: 0.75"

Formatted: Font: 12 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Font: (Default) Times New Roman

Formatted: Left, Indent: Left: 0", Tab stops: 0.41", Left

~~providers speaking the same language.~~

PROCEDURE

~~2.1 At a minimum, AAH's service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:~~

~~2.1.1 Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs~~and

~~2.1.2 Coordination of transportation to post-discharge appointments~~

~~2.1.3 Connection to any other on-going services an individual may require including mental health and substance use disorder services~~

~~2.1.4 Support in accessing benefits and housing~~

~~2.1.5 Gaining stability with case management relationships and programs~~

I. Eligibility

- Individuals who are at risk of hospitalization or are post-hospitalization;
- Individuals who live alone with no formal supports;
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification;
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations

~~2.2~~ AAH services provided to an individual while in recuperative care will not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other housing Community Supports will be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers.

~~2.3 AAH services provided will utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.~~

~~2.4 Member Identification~~

II. Referrals

a. Referrals to the Recuperative Care (Medical Respite) Community support can be received from:

i. The member themselves

Formatted: Font: 12 pt, Bold

Formatted: Font: 12 pt

Formatted: Bulleted + Level: 1 + Aligned at: 1.1" + Indent at: 1.35"

Formatted: Font: (Default) Times New Roman

Formatted: Font: 12 pt

Formatted: Font: (Default) Times New Roman

Formatted: Space Before: 5.95 pt, Bulleted + Level: 1 + Aligned at: 1.1" + Indent at: 1.35", Widow/Orphan control, Tab stops: Not at 1.1"

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.6", No bullets or

Formatted: Font: Bold

ii. A members representative

iii. A Members Provider

iv. Other internal departments at the Alliance

b. For members referred to community supports, where the community supports may not be the appropriate avenue, Case management and Enhanced Care Management referrals will be made to connect members to more appropriate services.

c. Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1– 888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

~~2.4.1 Referrals Based CS~~

~~2.4.2 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.~~

~~2.4.3 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.~~

~~2.4.3.1 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.~~

~~2.4.4 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1-888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.~~

~~2.4.5 Notification of Eligibility~~

~~2.4.5.1~~2.1.1.1 ~~AAH will notify members of Recuperative Care (Medical Respite) eligibility via telephonic communication~~.

III. Review

a) When the Alliance receives a request for Recuperative Care, they will review the documentation submitted by the provider. This will include the following:

1. Request for Recuperative Care (Medical Respite) Services by the Medical Respite provider
2. Documentation of Homelessness per HUD definition
3. Clinical Documentation to support the need for Recuperative Care as well as the need to heal from an acute injury/illness or an acute

Formatted: Font: Bold

Formatted: Indent: Left: 1.1", No bullets or

Formatted: Font: Bold

Formatted: Font: 12 pt

Formatted: Right: 0.44", Space Before: 6 pt, Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.85" + Indent at: 1.1", Tab stops: 1.68", Left + 1.68", Left + Not at 1.1" + 1.1"

exacerbation of a chronic illness

4. Coordinated entry enrollment documentation
5. Collaboration with the members ECM provider or ECM referral
6. Discharge plan

b) Once the information is reviewed, a decision will be made within the turnaround time standard and processes listed in the UM 057 policy.

c) Notifications will be made within the turnaround times and requirements listed in the UM 057 policy.

d) If a request is denied, the Member will have all rights associated with any UM decision as set forth in the UM 057 policy. A denial of a community supports service does not affect any other services the member is receiving.

IV. Closed Loop Referral

a) All referral and authorization requests will be tracked through the required DHCS closed loop referral process.

~~2.5~~

~~2.5.1 AAH verifies a member's health plan eligibility.~~

~~2.5.1.1 Request is reviewed~~

~~2.5.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM 057 Authorization Service Request.~~

~~2.5.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM 057, Authorization Service Request.~~

~~2.5.2 Urgent requests for Recuperative Care (Medical Respite) services will follow the standard AAH timeline in accordance with UM 051, Timeliness of UM Decision Making and Notification.~~

~~2.5.3 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.~~

~~2.5.4 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.~~

~~2.5.5 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:~~

~~2.5.6 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.~~

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 2 + Alignment: Left + Aligned at: 1" + Indent at: 1.25"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 4 + Alignment: Right + Aligned at: 1" + Indent at: 1.25"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.1" + Indent at: 1.35"

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

~~2.5.7 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).~~

~~2.5.8 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.~~

~~2.6 Continuity of Care~~

~~2.6.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.~~

~~2.6.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:~~

~~2.6.2.1 AAH offers the CS service which the member received through their prior MCP.~~

~~2.6.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.~~

~~2.6.3 AAH will automatically authorize the CS service when the above conditions are met.~~

~~2.7~~V. **Data Sharing**

~~2.7.1~~a) AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

~~2.7.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.~~

~~2.7.3~~b) AAH and CS Provider accesses available data exchange platform(s) when possible.

~~2.7.4~~c) AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

~~2.7.5~~d) AAH Collects, analyzes, and reports financial measures, health

Formatted: Font: 12 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 5 + Alignment: Right + Aligned at: 0.85" + Indent at: 1.1"

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1" + Indent at: 1.25"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.1" + Indent at: 1.35"

Formatted: Font: 12 pt

status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

~~2.8 Eligibility~~

~~2.8.1 Individuals who are at risk of hospitalization or are post-hospitalization, and~~

~~2.8.2 Individuals who live alone with no formal supports; or~~

~~2.8.3 Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.~~

~~2.9 Payment~~

~~2.9.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.~~

~~2.9.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:~~

~~2.9.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt~~

~~2.9.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt~~

~~2.9.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt~~

~~2.9.3 PMPM payments will be provided for applicable CS services (e.g., housing).~~

~~2.10~~VI. Restrictions and Limitations

~~2.10.1~~a) Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if:
1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

~~2.10.2~~b) Recuperative care/medical respite is an allowable Community Supports service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

~~2.10.3~~c) AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

~~2.11~~VII. Discontinuing Services

Formatted: Font: 12 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 6 + Alignment: Right + Aligned at: 0.85" + Indent at: 1.1"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.85" + Indent at: 1.1"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.85" + Indent at: 1.1"

Formatted: Font: 12 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 7 + Alignment: Right + Aligned at: 0.85" + Indent at: 1.1"

~~2.11.1~~a) Discontinuing of CS services will be based on:

- ~~2.11.1.1~~• Goals met/improved health status
- ~~2.11.1.2~~• Termination of coverage
- ~~2.11.1.3~~• No longer meets criteria
- ~~2.11.1.4~~• Member/caregiver declines services
- ~~2.11.1.5~~• Death of member

~~2.11.2~~b) CS provider will notify AAH CS team of AAH members who have discharged from Medical Respite within 1 week of discharge.

~~2.11.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.~~

~~2.12~~VIII. Licensing / Allowable Providers

~~2.12.1~~a) AAH CS Providers must have experience and expertise with providing these unique services.

~~2.12.2~~b) AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

~~2.12.3~~c) AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.1" + Indent at: 1.35"

Formatted: Bulleted + Level: 1 + Aligned at: 1.78" + Indent at: 2.03"

Formatted: Bulleted + Level: 1 + Aligned at: 1.78" + Indent at: 2.03"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.1" + Indent at: 1.35"

Formatted: Font: 12 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 8 + Alignment: Right + Aligned at: 0.85" + Indent at: 1.1"

Formatted: Font: 12 pt

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.1" + Indent at: 1.35"

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance
Cultural and Linguistic Services

RELATED POLICIES AND PROCEDURES

~~CM-026~~CS-006 Community Supports – Recuperative Care (Medical

CLS-009 CLS Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral ~~Process Flow~~SOP

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024, 9/18/2024, 04/01/2025

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CS-001 Community Supports – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	QI-114
Policy Name	Monitoring of Access and Availability Standards
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS
Effective Date	12/17/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") ensures its provider network is sufficient to provide accessibility, availability, and continuity of covered services, per the regulatory and contractual requirements of the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the National Committee for Quality Assurance (NCQA). The Alliance has established a mechanism for ongoing monitoring of its provider network to ensure timely access to and availability of quality health care services for all members within the Alliance and delegate network.

The Alliance performs ongoing monitoring of its direct and delegate provider network including these provider types:

1. Primary Care Providers (PCPs);
2. Behavioral Health (BH) providers; and
3. Specialists (SPC).

Ongoing monitoring is maintained to ensure network adequacy and address any areas of non-compliance or deficiency related to member's timely access to care and provider availability.

The Alliance will take all necessary steps and appropriate actions to maintain compliance with established Access and Availability standards within its provider network. When non-compliance or deficiencies are identified through the monitoring process, prompt investigation and corrective action is implemented to rectify identified deficiencies.

PROCEDURE

The Alliance Access and Availability (A&A) Committee reviews monitoring reports to determine that:

- provider network geographic distribution,
- provider language capabilities,
- provider capacity levels,
- network adequacy,
- timely appointment availability, and
- provider availability

are compliant with regulatory and accreditation access and availability standards. All monitoring reports and analyses are reviewed at the A&A Committee for evaluation and recommendations of opportunities for improvement.

Access & Availability Reports

Descriptions of the access and availability monitoring reports that are analyzed and reported to the A&A Committee are as follows:

1. Provider Network Capacity

A. Provider Services department staff review network providers whose member assignments are approaching the 2,000:1 capacity ratio of members to PCPs (PRV-003 Provider Network Capacity Standards).
   i. Monthly provider capacity reports are developed after the monthly auto-assignment procedures are completed.
      a. Providers nearing the 2,000 capacity mark (≥1,900)) are flagged and auto-assignment enrollment is closed.

ii. Provider Services department staff review and track network providers who are at 80% of capacity and above to ensure they do not exceed their capacity threshold.

iii. As appropriate, Provider Services department staff will notify those network providers who are at 80% of capacity and above and will continuously monitor them on a monthly basis. For those network providers who have reached 90% capacity, Provider Services department staff will close them to auto assignment.

iv. For those network providers identified by Provider Services as being below 80% of capacity, Provider Services department staff will remove the flag and enrollment will be reopened to allow the provider to have additional membership assignment up to the 2,000: 1 capacity level.

v. For those network providers found over capacity, Provider Services department staff will reassign their members to another provider and they will be closed to new members.

vi. Those providers will be sent a written notice from Provider Services department staff regarding closed assignment.

vii. QI management will conduct a Quality Access to Care (QOA) audit on all providers who have been identified by Provider Services as having reached the ≥80% member capacity threshold to evaluate the providers access to care compliance. Audit results are reported to the Access and Availability committee to determine if closure of assignment is warranted.

2. Provider Appointment Availability Survey (PAAS)

The Alliance, in conjunction with its Analytics department, annually conducts a Provider Appointment Availability Survey (PAAS) of its PCP, specialty, ancillary, and BH provider network, to ensure provider compliance with the DMHC appointment availability standards, and in accordance with the DMHC PAAS Methodology. Directly contracted providers, as well as the plan's delegated network, are included in the PAAS (QI-116 Provider Appointment Availability Survey).

Based on results of the PAAS, the Alliance Quality Improvement (QI) staff will outreach to providers found to be non-compliant with the standards, as well as non-responsive to the survey. QI staff will inform providers of the survey results, provide re-education on the DMHC appointment availability standards, and issue corrective action plans (CAPs) accordingly. The timely access to care standards are noted in the Provider Directory in the section "Timely Access to Care". In addition, when an ineligible provider is found as a result of PAAS, the respective Alliance Department will send notice to Provider Services team to update the Provider Repository.

3. DHCS First Prenatal Visits (Non-PAAS)

The Alliance, in conjunction with its Analytics department annually conducts a survey of its obstetrics/gynecology (OB/GYN) provider network to ensure provider compliance with the DHCS first prenatal visit standard within 2 weeks of the request. Based on survey results, QI staff will outreach to providers found to be non-compliant with the visit standard, as well as non-responsive to the survey. QI staff will inform providers of the survey results, provide re-education on the DHCS first prenatal visit standard, and issue CAPs accordingly.

Providers who may be excluded from the survey include:

- Hospitalists

4. After-Hours Survey

The Alliance, in conjunction with its QI department and its vendor Press Ganey (PG), at least annually conducts an After-Hours Survey to ensure provider compliance with after-hours (post normal business hours) access and emergency instructions standards, per the DHCS, DMHC, and NCQA regulatory and accreditation requirements. The surveys assess compliance with timely access to a physician or an appropriate licensed professional, as well as with availability of member instructions when experiencing a medical emergency. Based on survey results, QI staff will outreach to providers found to be non-compliant with the after-hours standards, inform them of the survey results, provide re-education on the standards, and issue CAPs accordingly. For those providers identified in the surveys as having potential issues with accurate contact information, QI staff communicate interdepartmentally (Provider Services and Data Analytics to ensure provider information accuracy for future surveys, as well as consider conducting confirmatory surveys as appropriate to ensure provider compliance with the afterhours standards).

Provider types who may be excluded from the After-Hours Survey include:

- Pathologists
- Radiologists
- Emergency Medicine Providers
- Physical and Occupational Therapists
- Hearing Aid Dispenser Providers
- Applied Behavioral Analysis (ABA) Providers
- Board Certified Behavior Analyst (BCBA) Providers
- Chiropractors
- Registered Dieticians
- Hospitalists
- Medical Geneticists
- Anesthesiologists

5. Facility Site Reviews (FSRs)

Facility Site Reviews (FSRs) and medical record reviews (MRRs) are conducted on a periodic basis to ensure compliance with the DHCS requirement (Contract, All Plan Letter, and Policy Letter) (QI-105 Primary Care Provider Site Reviews). FSR and MRR evaluations capture provider office compliance with handling missed/broken appointments for diagnostic procedures, lab tests, specialty appointments, and/or other referrals, as well as attempts to contact the member/parent to reschedule appointments. CAPs are issued to providers as needed (refer to escalation process workflows for providers non-responsive to FSR CAPs and for providers non-responsive to critical element CAPs).

6. Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)

The Alliance, in conjunction with its vendor PG, as often as quarterly conducts PCP, Behavioral Health, and Specialist post-visit survey. The CG-CAHPS measures member experience with health care providers and staff, as well as with in-office wait time, provider time to answer calls during business hours, and provider call return time during business hours. An escalation process for providers identified as non-compliant with CG-CAHPS describes the specific steps taken during the non- compliance periods to ensure appropriate follow up (refer to CG-CAHPS escalation process workflow).

Commented [MS1]: Added to address DHCS preliminary findings

7. High-Volume and High-Impact Specialists

On a quarterly basis, the Alliance reviews the geographic access ratio standards of a subset of specialists identified as high-volume specialists for monitoring of specialist availability within the network (PRV-003 Provider Network Capacity Standards).

Specialists that are reviewed include but are not limited to:

- Cardiologists
- Endocrinologists
- Gastroenterologists
- OB/GYNs
- Psychiatrists
- Licensed Clinical Social Worker
- Licensed Marriage & Family Therapist
- Psychologists

The number of unique members is also identified to determine if access to appointments with high-volume specialists is sufficient for members, per requirement of NCQA.

On a quarterly basis, the Alliance reviews the geographic access ratio standards of a subset of specialists identified as high-impact specialists for monitoring of specialist availability within the network (PRV-003 Provider Network Capacity Standards).

Specialists that are reviewed include:

- Oncologists

8. Geographic Accessibility

On a quarterly basis, geographic accessibility reports are reviewed by the Geo Access workgroup (comprised of Provider Services, QI, UM, Operations and Compliance) and used to identify geographic areas potentially lacking access to specific provider types, including, but not limited to, PCPs, specialists, BH providers, hospitals, pharmacies, and ancillary services (PRV-003 Provider Network Capacity Standards).

The A&A Committee will determine whether additional recruitment is needed by particular provider types, or whether the Alliance shall request alternative access standards for areas lacking access. If approved by DHCS, the Alliance will adopt the alternative access standards for the designated area.

9. Access-Related Potential Quality Issues (PQIs)

Upon identification, access-related PQIs (quality of access issues, QOAs) investigated by clinical staff are forwarded to A&A QI staff. A&A Staff will

- Review the QOA issues, check claims data to ensure that the member was not admitted nor went to an Emergency Department. If the member was admitted or went to the ED, the case will be sent to the QI RN Supervisor.
- In addition, the A&A staff member will review MRs if available to ensure that the Member's medical record notes that a longer waiting time will not have a detrimental impact on the health of the Member. MRs may be available through G&A and / or if there is a corresponding QOC case. If this is not properly documented, A&A staff will ensure appropriate provider education.
- Finally, A&A staff will conduct confirmatory surveys calls to provider office to assess timely access compliance. All QOAs requiring confirmatory survey outreach are tracked and trended for compliance performance improvement and issuance of CAPs as warranted.
- For additional information, please see the QOA Workflow. For QOC / QOA cases, the A&A team will randomly select cases on a semi-annual basis to appropriate documentation if a member's appointment was extended. The medical record but document that longer waiting time will not have a detrimental impact on the health of the member. This report will be brought to the A&A Sub-committee for review and appropriate escalation.

10. Extending Member Appointment Timeframe

- On review of the medical records, the record must indicate that:
    - Waiting will not have a detrimental impact of the Member's health as determined by the treating health care provider
    - The provider's decision to extend the applicable waiting time is noted in the Medical Record and is available to DHCS upon request
    - The Provider's decision to extend the applicable waiting time must include an explanation of the Member's right to file a Grievance disputing the extension

11. Grievances & Appeals Related to Access

Grievances related to access are reviewed quarterly within Joint Operations Meetings with delegated providers and within the quarterly A&A Committee meetings to identify providers and/or delegates with potential access issues.

A&A QI staff engage in tracking and trending of identified providers/groups/delegates to assess for potential trends in non-compliance within other access-related monitoring reports. If providers/groups/delegates are identified as having a trend of non-compliance with access standards, A&A staff will follow-up with providers and will issue CAPs to address identified deficiencies as appropriate.

12. Provider Language Capacity and Quality of Language (QOL) PQIs Reporting

A. These reports are reviewed quarterly at the Cultural and Linguistic Services (CLS) Committee to inform the Alliance's Provider Services department whether focused contracting efforts are needed for providers who speak languages underrepresented based on the Alliance's Provider Access by Language data report.
B. The Provider Access by Language data report shows a comparison of providers' spoken languages with the demographics of the Alliance's membership.
C. The report also provides needed information for updating the Alliance's Language Assistance Program.
D. Provider language and interpreter capacity is audited annually by the Health Education Department to track and trend and evaluate language access services compared to the prior year.

13. Confirmatory Surveys

Confirmatory surveys are conducted internally and on an ad-hoc basis to assess a random selection of providers against a timely access standard. The selection of providers may include, but is not limited to, the following: those previously issued CAPs; those for whom "spot checks" have been requested; those for whom surveys are indicated subsequent to identification of potentially inaccurate contact information; and others as appropriate. The timely access standards that will be assessed for compliance via these surveys may include, but are not limited to, the following: provider call return time during business hours; provider time to answer call during business hours; urgent, non-urgent and/or first OB/GYN pre-natal provider appointment availability; and after-hours emergency instructions protocol or telephone access to an appropriate licensed professional.

14. Consumer Assessment of Healthcare Providers and Systems 5.1H(CAHPS)

The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey that uses a valid and statistically reliable survey methodology. The survey is designed to measure member experience with the health plan and affiliated providers. The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

15. Medicare Consumer Assessment of Healthcare Provider and Systems (MCAHPS)

The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey that uses a valid and statically reliable survey methodology. The survey is designed to measure members' experiences with obtaining health care and prescription drug coverage. The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

16. Medicare Health Outcomes Survey (HOS)

The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey that uses a valid and statically reliable survey methodology. The survey is designed to see how well health plan help beneficiaries maintain or improve their health over time. The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

17. Timely Access Requirements (TAR) Survey

The Alliance, in conjunction with its vendor PG, conducts an annual member satisfaction survey. The survey is designed to obtain enrollees' perspectives and concerns regarding their experiences obtaining timely appointments and interpreter services for health care services. The survey findings are analyzed to identify opportunities to improve members' access to interpreter services.

18. Provider Satisfaction Survey

The Alliance, in conjunction with its vendor PG, conducts an annual provider satisfaction survey that uses a valid and statistically reliable survey methodology. The survey is designed to measure level of satisfaction with the health plan of Alliance-contracted physicians, non-physician medical providers, and mental health providers. The survey assesses health plan performance in key service areas including all other plans (comparative rating), finance, utilization and quality management, network/coordination of care, pharmacy, call center service, provider relations, overall satisfaction, timely access to health care services for members, and interpreter services.

Provider types who may be excluded from the Provider Satisfaction Survey include:

- Pathologists
- Radiologists

- Emergency Medicine Providers
- Physical and Occupational Therapists
- Hearing Aid Dispenser Providers
- Applied Behavior Analysis (ABA) Providers
- Board Certified Behavior Analyst (BCBA) Providers
- Chiropractors
- Registered Dieticians
- Hospitalists
- Medical Geneticists
- Anesthesiologists

Follow-up Actions

Based on qualitative and quantitative analyses of monitoring reports and Quality Committee recommendations, QI staff may engage in any of the following actions:

A. Targeted outreach and marketing campaigns to recruit additional providers and maintain the existing network
B. Negotiations with existing providers to accept additional members and/or to place a hold on assignment of new membership to over-assigned providers
C. Revision of member and provider directories, manuals, and bulletins
D. Tracking and trending of report data to identify best practices and opportunities for improvement
E. Issuing a CAP
F. Education/re-education and outreach (face-to-face, verbal, and/or written) to non-compliant and/or non-responsive providers with a follow-up plan to resurvey within a specified timeframe to assess/reassess compliance with timely access standard(s)
G. Discussions at Joint Operations Meetings (for delegates)
H. Referral to the Chief Operating Officer (COO) and Chief Financial Officer (CFO) for discussion and recommendations for next steps (for delegates)
I. Referral to the Credentialing Committee (CC), and/or to the Peer Review Committee (PRCC) as appropriate, for discussion and recommendations for next steps
J. Other actions as appropriate

Corrective Action Plans (CAPs)

When deficiencies or patterns of non-compliance are found through the monitoring process, the Alliance will issue time-sensitive CAPs to all identified contracted providers and delegates.
The written CAP includes the following:

1. A description of the identified deficiencies
2. The rationale for the CAP
3. The name and telephone number of the QI staff member authorized to respond to provider concerns regarding the CAP issued

4. The due date (within 60 calendar days).
5. For SNC, delegates has six months to correct all deficiencies and action steps that delegates is undertaking to address the CAP.

CAP responses are required to include the following:

1. Corrective action steps providers will take to mitigate the deficiency
2. Supporting documentation demonstrating how the deficiency will be/has been corrected and processes that will be/have been put in place to ensure compliance with regulatory standards and/or contractual requirements
3. Responsible person(s) (name and title) who will address and correct the identified deficiency
4. The target completion date for when the CAP will be completed.

Where CAP responses have been satisfactorily received within the identified timeframe, non-clinical CAPs will be reviewed and closed by A&A management staff within ten (15) business days of receipt of the CAP response. Facility Site Review (FSR) Clinical CAPs will be escalated according to the "Escalation Process for Providers Non-Responsive to Critical Element CAPs."

The Access & Availability Committee will report during each meeting:

- A CAP dashboard showing CAPs issued and closed since the previous Committee meeting
- An update regarding outstanding CAPs that require additional action and/or possible escalation, as appropriate.

MONITORING

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

DEFINITIONS / ACRONYMS

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

High-Impact Specialist – A type of specialist who treats specific conditions that have serious consequences for the member and require significant resources.

High-Volume Provider - A PCP, a specialist, a provider of ancillary services, or a CBAS provider who has provided a minimum of 500 outpatient visits to 200 unique members, based on total encounters/claims within the year exclusive of encounter/claims data from CHME, ModivCare, and PerformRx.

PG – Press Ganey.

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

PRV-003 Provider Network Capacity Standards
QI-104 Potential Quality Issues
QI-105 Primary Care Provider Site Reviews
QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-115 Access and Availability Committee
QI-116 Provider Appointment Availability Survey (PAAS)
QI-117 Member Satisfaction Survey (CAHPS)
QI-118 Provider Satisfaction Survey
CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
DAT-001 Provider Data and Directories

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Escalation Process for Providers Non-Responsive to Access CAPs
Escalation Process for Providers Non-Responsive to FSR/MRR CAPs
Escalation Process for Providers Non-Responsive to Critical Element CAPs Escalation Process for Providers Non-Compliant with CG-CAHPS

Access-Related PQIs Workflow

After-Hours Survey Tool
After Hours Access Methodology
Provider Appointment Availability Survey Tool
First Prenatal Visit Survey Tool

Facility Site Review Tool Medical Record Review Tool
CG-CAHPS Survey Tool
CAHPS 5.1H Survey Tool
Provider Satisfaction Survey Tool
Alliance Timely Access Standards

REVISION HISTORY

12/17/2015, 11/10/2016, 3/9/2017, 10/17/2017, 3/01/2018, 11/16/2018, 3/21/2019, 5/16/2019, 3/19/2020, 5/20/2021, 6/28/2022, 11/15/2022,11/15/2022,2/17/2022, 3/21/2023, 12/19/2023, 6/12/2024, 12/18/2024

REFERENCES

QI-114 Monitoring of Access and Availability Standards

DHCS Contract Exhibit A, Attachment 9, Access and Availability DHCS Contract, Exhibit A, Attachment 4-10 and 13

DHCS MMCD All Plan Letters 02-006, 03-006, 03-007, and 15-023

DHCS MMCD Policy Letter 12-006, and 14- 004 Title 28, CCR, Section 1300.67.2.2(c)(8)(A)(B)

NCQA 2021 Standards and Guidelines for the Accreditation of Health Plans, Net 2: Accessibility of Services

DMHC Provider Appointment Availability Survey Methodology Measurement Year 2020

~~MONITORING~~

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

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	QI-133
Policy Name	Inter-Rater Reliability (IRR) - Testing for Clinical Decision Making
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Medical Director
Lines of Business	MCAL, IHSS, MCARE/DSNP
Effective Date	11/15/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

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

PROCEDURE

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

As such, this P&P applies to the following categories of staff that will be tested as separate groups given that their decision-making responsibilities are discrete from one another:

1. Physicians
2. Prior Authorization Clinical Reviewers

3. Inpatient Concurrent Review Nurses
4. Pharmacists
5. Quality Review Nurses
6. Long- Term Care Nurses
7. Psychologists
8. Behavioral Health Nurses, LCSWs and LMFTs

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

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

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

Overall Process and Methodology

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

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

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

Pharmacy: Clinical Decision Reviewers

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

On an annual basis, the Director of Pharmacy or Clinical Designee will randomly select 30 cases from the previous 12 months based on applicable case types and settings. The Pharmacy Director or Clinical Designee will have 8 cases reviewed for the accuracy of decisions. The Pharmacy Director or clinical designee will review the pharmacist determination results for each pharmacist to identify opportunities for education and process improvement. The results of the pharmacist case determinations IRR will be compiled to produce the Pharmacy Determination Accuracy Report. The Pharmacy Determination Accuracy report will be reported to the P&T Sub-Committee on an annual basis

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

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

Quality Improvement: Clinical Decision Reviewers

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

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

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

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

Grievance and Appeals: Clinical Decision Reviewers

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

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

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

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

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

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

Utilization Management: Clinical Decision Reviewers

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

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

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

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

scenario will address the:

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

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

Utilization Management: Non-Clinical Decision Reviewers

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

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

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

Behavioral Health: Clinical Decision Reviewers

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

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

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

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

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

Case results are provided immediately within the MCG module application and reviewed based on the scoring table below. In the setting situations where there is no case scenario or not enough cases in

the MCG Module, case results will be provided within 2 weeks of completion of the IRR.

Act on Opportunities

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

Score	Attempt 1: Action	Attempt 2: Action	Attempt 3: Action
High 90%-100%	No Action Required	No Action Required	No Action Required
Medium 71%-89%	Independent Materials Review then Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios and/ or employee Retakes the IRR Test	Additional training and with Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios and/ or employee Retakes the IRR Test	Additional training and with Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios and/ or employee Retakes the IRR Test
Low Below 70%	Additional training and with Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios and/ or employee Retakes the IRR Test. On-going oversight based on discretion by the Manager/Director	Additional training and with Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios and/ or employee Retakes the IRR Test. On-going oversight based on discretion by the Manager/Director	If staff three times fails to pass the IRR, the case will be escalated to Human Resources which may result in further disciplinary action such as a Corrective Action Plan

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

Delegate Oversight

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

DEFINITIONS

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

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments responsible for clinical reviews

RELATED POLICIES AND PROCEDURES

None

RELATED WORKLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/15/18, 3/21/19, 4/27/20, 3/18/21,03/22/2022, 03/21/2023, 6/12/2024, 5/2/2025

REFERENCES

None

MONITORING

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

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	MBR-024
Policy Name	Exempt Grievances
Department Name	Member Services
Department Officer	Chief Operations Officer
Policy Owner	Sr. Director, Member Services
Line(s) of Business	MCAL, IHSS
Effective Date	4/13/2015
Compliance Committee Approval Date	~~4/10/2024~~

POLICY STATEMENT

Alameda Alliance for Health ("AAH") has established and annually reviews and updates written procedures for the submittal, processing, and resolution of Exempt Grievances ("EG" or "Complaints"). An Exempt Grievance is any member complaint that meets the following criteria:

1) is not related to coverage disputes, disputed health care services involving Medical Necessity, or experimental or investigational treatment;
2) ~~-~~ is resolved by the close of the next business day following receipt.

Any revisions to this policy shall be approved in writing by the Department of Health Care Services (DHCS) prior to use.

AAH has a system for receiving, processing, and resolving complaints from Members or their Authorized Representatives (AOR) regarding the care and services they receive from AAH's providers and contractors or staff. AAH Member Services Representatives (Representatives) shall manage all Member Complaints in a fair, respectful, timely, consistent, and culturally/linguistically appropriate manner in accordance with relevant regulatory requirements Communications with Members/AORs regarding their complaints will be done in a culturally appropriately manner and will be in the Members'/AOR's primary languages, including American Sign Language and telephone relay systems when appropriate. Language service assistance, including translation services, will be made available throughout the Complaint process described herein.

Representatives log Member Complaints in Healthsuite as a Service Request (SR). Documentation of Member Complaints shall include a summary of the Complaint as communicated by the Member/AOR. The SR shall also include any actions taken by AAH to resolve the Complaint. Complaints which are not resolved by close of next business day are

routed to the AAH Grievances and Appeals Department (G&A) for further processing and documented in an SR.

Members who file Complaints of suspected provider or AAH plan misconduct will not be retaliated against by AAH or any AAH employee for making such a report in good faith.

PROCEDURE

A. <u>Process for Receiving Complaints</u>

The Department processes Member Complaints received by phone, mail, email, fax, in person, and online. The case is entered and categorized by the MSR during the intake of the call utilizing training guides (Exempt Grievance Guide), provided by the Quality Improvement Medical Director. Once the case is categorized it goes into a queue to verify the correct categories were selected by the MS Supervisor and/or designee. If the Complaint is related to denied services, coverage disputes, or authorization decisions, then the Representative logs the Complaint as a Standard Grievance in Healthsuite. The complaint is auto populated in the grievance system application (Qualitysuite) to process by the G&A Unit as an appeal or a complaint (expedited or standard).

For Timely Access Dissatisfactions: If the complaint involves a timely access complaint and the MSR is unable to secure a timely appointment (utilizing the DHCS/DMHC/NCQA Timely Access Standards) for the member within the EG resolution timeframe (with the provider the member is having the access issue with), the case is recategorized as a standard G&A for processing.

For exempt grievances, the Member Services Representative, with the help of their Supervisor, Trainer, and/or Quality Assurance Specialist, is responsible for the final resolution determination. The Representative provides a resolution to the Member or AOR by 5 pm PST, the next business day. If the Complaint cannot be resolved by 5 pm PST the next business day, the Complaint is forwarded to G&A to process as a Standard Grievance. If the designated reviewer determines that a Complaint is related to a Potential Quality Issue (PQI) the reviewer checks the PQI indicator in Qualitysuite which flags the case for AAH Quality Improvement Unit for further review.

B. <u>Documentation of Complaints</u>

The Department logs all Complaints as SRs in Healthsuite. The SR documentation includes the following information for each Complaint:

i. The date of the call.
ii. The name of the Complainant.
iii. The Complainant's member identification number.
iv. The nature of the Complaint.
v. The nature of the resolution.
vi. The name of the Representatives who took the call and resolved the Complaint.
vii. The resolution date.

a. If the Department is unable to resolve the member's Complaint by the close of the

next business day, the Department will document the date when the exempt grievance was forwarded to G&A as a standard grievance.

DEFINITIONS / ACRONYMS

DEFINITIONS

Appeal - a request for review of one of the following actions:

A. A denial or limited authorization of a requested service, including the type or level of service;

B. A reduction, suspension, or termination of a previously authorized service;

C. A denial, in whole or in part, of payment for a service;

D. Failure to provide services in a timely manner; or E. Failure to act within the timeframes provided in 42 CFR 438.408(b

Complaint – an expression of dissatisfaction regarding the health plan, policies or processes, providers, or any other aspect of health care delivery through AAH. Complaint is another term used to describe an Exempt Grievance.

Complainant – The person who filed the complaint including the Member, a representative designated (Authorized Representative) by the Member, or other individual with authority to act on behalf of the Member.

Exempt Grievance – A written or oral expression of dissatisfaction that is not related to coverage disputes, disputed health care services involving Medical Necessity, or experimental or investigational treatment and that are resolved by the close of the next business day following receipt. Exempt Grievances may also be referred to as Complaints.

Expedited Grievance – A grievance or appeal involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of limb, or major bodily function are reviewed expeditiously and resolved within 72 hours or sooner if the medical condition requires.

Grievance – A written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care or service concerns, including any breaches of confidentiality surrounding protected health information, and may include a complaint, dispute, or a request for reconsideration made by a Member or the Member's authorized representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it will be considered a grievance.

Potential Quality Issues - An event or pattern of behavior that may indicate a significant risk to the health and/or wellbeing of the member or members.

Resolved – The complaint has reached a final conclusion with respect to the Member's submitted grievance, and there are no pending Member appeals within AAH's grievance system, including entities with delegated authority.

Standard Grievance – Grievances that require a written acknowledgement and resolution and is resolved within 30 calendar days.

Service Request (SR) – a way to document, track and trend each contact using specific contact reason categories in the member's account in HealthSuite.

AFFECTED DEPARTMENTS/PARTIES

Member Services Department
Quality Improvement Department
Information Technology
Grievance and Appeals Department
Access and Availability Subcommittee
Provider Services Department
Compliance Department

RELATED POLICIES AND PROCEDURES

1. G&A - 001 Grievance System Description
2. G&A – 002 Grievance Filing
3. G&A – 005 Expedited Review of Urgent Grievance and Appeals

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Medi-Cal Evidence of Coverage
Group Care Evidence of Coverage
Member Service Training Manual
Member Services Department Grievance Guide
Access Related Complaints SOP

REVISION HISTORY

4/13/2015, 6/16/2016, 11/10/2016, 10/18/2018, 11/15/2018. 5/16/2019,07/16/2020, 11/23/2021, 01/11/2023, 10/19/2023, 4/10/2024. 5/01/25

REFERENCES

Medi-Cal Managed Care Plans Primary Operations Contract - Section 4.6 Member Grievance and Appeal System

DHCS APL21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates

Title 28, California Code of Regulations, §1300.68(d)(8)

CA Health and Safety Code section 1368(a)(4)(B)

National Committee for Quality Assurance (NCQA)

- ME – 7 Member Experience

Alameda Alliance for Health Policies and Procedures

- CMP-029
- QI-104

MONITORING

Monitoring Activities

Department leadership (Supervisor or designee) reviews ~~a~~an Exempt Grievance SR Report that is generated from Healthsuite to ensure complaints have been coded appropriately for processing purposes.

The daily Exempt Grievance SR Report (which is auto generated from HealthSuite service requests) is monitored monthly and analyzed to identify Complaint trends and areas of high volume needing further review or escalation. Complaints related to access, quality of service, and quality of care are analyzed monthly to determine whether any patterns or trends are occurring with specific provider types or due to network concerns.

Staff training on "Grievances and Appeals" is conducted as part of the Member Services New Hire training program by the Learning Development and Quality Supervisor. Additional ad-hoc training is conducted by either the QA and Regulatory Reporting Manager or the Learning Development and Quality Supervisor. Training would consist of changes to any applicable state regulation, and implementation of new or updated policy and procedures. Training is documented and attendance is recorded of the participants involved.

Any~~, Complaints~~ complaints related to Access and Availability are reported by the Grievance and Appeals Department to the Access & Availability Committee and Compliance quarterly for review and required reporting to DHCS.

Exempt grievances related to quality of care are reported to the Quality Improvement Department for further review as PQIs.

The Department Quality Assurance Team reviews call recordings (randomly selected) to ensure that Complaints are logged accurately and resolved in a timely manner. (MBR-003 Quality Monitoring of Member Communications).

The Alliance Compliance Department, Internal Audit Team, conducts periodic internal audits of processes and procedures throughout the Alliance, based upon policy CMP-029, Internal Audit.

~~G&A~~ Grievance and Appeals tracks and trends complaints, grievances, and appeals by line of business, provider type, specialty type, delegates, specific provider/provider groups and reports the results of these monitoring activities to the Quarterly Access & Availability Committee, Compliance Committee, Ongoing Monitoring Workgroup, UM Committee, Joint Operations Meetings with Delegates (JOMs), CLS Committee, and Quality Improvement Health Equity Committee as applicable.

This policy will be reviewed annually to meet regulatory and contractual standards and maintain effectiveness.