Quality Improvement Health Equity Utilization Management Committee Voting Items

Policies & Procedures
August 14, 2026

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

Policy Procedures Summary of Changes

Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update (X)	New Policy (X)	Annual Review or Formatting Changes (X)	Retire (X)	Presenter	Subcommittee Approval Date (QIHEC, PRCC, P&T) if applicable
QI	107	Appointment Access and Availability Standards	Describes how the Alliance implements and maintain procedures for members to obtain appointments for routine (non-urgent) and urgent care from all applicable provider types.	Annual review, minor formatting changes			X		Loc Tran	
QI	108	Access to Behavioral Health Services	Describes how the Alliance implements and maintain procedures to ensures the Alliance complies with the access and availability standards set by DMHC and DHCS.	Annual review, minor formatting changes			X		Loc Tran	
QI	116	Provider Appointment Availability Survey (PAAS)	Describes the PAAS survey process designed to monitor Alliance delegated and directly contracted provider compliance with access and availability standards for Alliance members.	Annual review, minor formatting changes			X		Loc Tran	
Quality Improvement	HED-001	Health Education Program	Descibes Alliance Health Education Program Elements	Minor upates based on DHCS nomenclature changes from *PNA* to *Local Planning* in PHM Policy Guide.			X		Gil Duran	
Quality Improvement	HED-002	Health Education Materials	Describes process for creating and approving health education and member informing materials.	Annual update.			X		Gil Duran	
Quality Improvement	HED-006	SABIRT Services	Describes alcohol and drug screening, assessment, brief interventions and referral to treatment benefit.	Annual update.			X		Gil Duran	
Quality Improvement	HED-007	Tobacco Cessation	Describes Alliance policy on tracking tobacco use and implementing cessation services.	Annual update.			X		Gil Duran	
Quality Improvement	HED-009	Diabetes Prevention Program	Describes how the Alliance offers the Diabetes Prevention Program to eligible members.	Minor refinements to D-SNP coverage language. Annual update.			X		Gil Duran	
Quality Improvement	HED-010	Doula Services	Describes how the Alliance offers the Doula Benefit to eligible members.	Annual update.			X		Gil Duran	
Quality Improvement	PH-001	Population Health Management Program	Descibes the elements of the Alliance's Population Health Management Program in alignment with the DHCS PHM Policy Guide. Refers to Alliance policies and procedures that detail Alliance population health management elements and programs.	Updated the PHM Program policy to align with the DHCS PHM Policy Guide by updating definitions and terminology for Local Planning and CHA/CHIP participation. The policy was also updated to align with NCQA Health Outcomes Accreditation standards by expanding health disparities monitoring, stratification, intervention, and evaluation requirements across race/ethnicity, language, disability status, geographic classification, and other demographic factors.	X				Gil Duran	
Quality Improvement	PH-002	Basic Population Health Management	Describes Alliance Population Health Management supports including provision of BPHM services by PCPs, role of Alliance ECM, LTC and Care Management staff, Wellness and Prevention activities and refers to related P&Ps and services.	Annual update.			X		Gil Duran	
Quality Improvement	PH-003	Risk Segmentation and Stratification	Describes Alliance Population Health Management data sources and processes for risk stratification and segmentation of members.	Annual update.			X		Gil Duran	
Quality Improvement	PH-005	Population Assessment	Describes how the Alliance understands and assesses its member population and subpopulations by demographics, health, utilization, SDOH and other characteristics in compliance with DHCS PHM Policy Guide and NCQA PHM requirements.	Minor updates to align definitions with PHM Policy Guide and refinements to D-SNP language. Annual update.			X		Gil Duran	
QI	TBD	Member Data Collection, Race and Ethnicity– HO2: Element A, Collection of Data on Race and Ethnicity	Describes direct data collection methods for member race and ethnicity.	New policy to meet changes to NCQA Health Outcomes requirements		X			Linda Ayala	
QI	TBD	Member Data Collection, Language– HO2: Element B, Collection of Data on Language	Describes direct data collection methods for member language.	New policy to meet changes to NCQA Health Outcomes requirements		X			Linda Ayala	
QI	TBD	Member Data Collection, Disability Status– HO2: Element D, Collection of Data on Disability Status	Describes direct data collection methods for member disability status.	New policy to meet changes to NCQA Health Outcomes requirements		X			Linda Ayala	

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QI	TBD	Member Data Collection, Sexual Orientation – HO2: Element C, Collection of Data on Sexual Orientation	Describes direct data collection methods for member sexual orientation.	New policy to meet changes to NCQA Health Outcomes requirements		X			Linda Ayala	
QI	TBD	Geographic Classification– HO2: Element F, Classification of Geographic Data	Describes standardized methodology for member geographic classification.	New policy to meet changes to NCQA Health Outcomes requirements		X			Linda Ayala	
Long Term Care	001	Long Term Care Program	Overview of Long Term Care program, including LTSS Liaison and Quality Monitoring expectations	Added new DHCS APL requirement to host quarterly LTC Provider webinars; updated APL references to current note: Policy is posted publicly	X				Allison Lam	
Long Term Care	002	Authorization Process and Criteria for Admission, Continued Stay, and Discharge from a Long-Term Care Facility	Outlines Medical Necessity Review process, including authorization and clinical documentation requirements, turnaround times, and member/provider notification expectations	Added regulatory reference noting the inability for health plan to pay nursing facilities and subacute facilities if federal PASRR process is not completed; added allowable authorization durations (up to 2 years, at the discretion of the reviewer) note: Policy is posted publicly	X				Allison Lam	
Long Term Care	004	LTC Bed Hold and Leave of Absence	Outlines requirements for Bed Hold and Leave of Absence requests, including required clinical documentation requirements	Added documentation requirements to review Bedhold and Leave of Absence requests, per DHCS LTC Provider Manual; added process for updating existing authorizations with bedhold dates note: Policy is posted publicly	X				Allison Lam	
CLS	001	Cultural and Linguistic Program Description	Describes elements of the Alliance Cultural and Linguistic Services including objectives, activities, roles, work plan and organization chart.	Minor grammar and formatting updates. Updated Alliance logo.			X		Linda Ayala	CLSS: July 22, 2026
CLS	002	Community Engagement	Describes role, function and policies for the Alliance Community Advisory Committee.	Minor grammar and formatting updates. Committee reference updated from QIHEC to QIHE/UMC. Updated: Alliance logo CAC Duties CAC Attendance			X		Linda Ayala	CLSS: July 22, 2026
CLS	003	Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities	Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities	Minor formatting and wording updates. Added the following definition: discrimination grievance. Added the term, "race" in Member Identification section. Updated: Alliance logo Alternative Format Selection (AFS) to comply with Primary Contract-Amendment 11			X		Linda Ayala	CLSS: July 22, 2026
CLS	008	Member Assessment of Cultural and Linguistic needs	Member Assessment of Cultural and Linguistic needs	Minor formatting updates. Separated "race" and "ethnicity". Updated Alliance logo.			X		Linda Ayala	CLSS: July 22, 2026
CLS	009	CLS Program - Contracted Providers	CLS Program - Contracted Providers	Minor formatting updates. Committee reference updated from QIHEC to QIHE/UMC. Updated Alliance logo.			X		Linda Ayala	CLSS: July 22, 2026
CLS	010	CLS Program - Staff Training and Assessment	CLS Program - Training and Assessment	Updated Alliance logo.			X		Linda Ayala	CLSS: July 22, 2026
CLS	011	CLS Program - Compliance Monitoring	CLS Program - Compliance Monitoring	Minor grammar and formatting updates. Committee reference updated from QIHEC to QIHE/UMC. Updated Alliance logo.			X		Linda Ayala	CLSS: July 22, 2026
CMDM	CM-002	Complex Case Management Plan Development and Management	CCM Care Plan Development	addition of language around provider method and frequency of collaboration	X				Lily Hunter	
CMDM	CM-019	Private Duty Nursing Case Management For Members under the age of 21	CM for members receiving private duty nursing	addition of APL 26-009 language, members may decline CM	X				Lily Hunter	

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CMDM	CM-046	Plan Responsibilities IHCP and American Indian Members	Responsibilities of AAH related to Indian Health Care Providers (IHCP) and American Indian Members in alignment with APL 24-002	new policy		X			Lily Hunter	
BH	BH-XXX	Behavioral Health Data Sharing	New policy to address APL 24-004 which requires MCPs share BH data with state, contracted network providers, and Alameda County Behavorial Health. Requires the use of DHCS consent forms for the release of BH information.	new policy		X			Andrea DeRochi	
UM	UM-001	Utilization Management Program	Overall UM Program Guidelines including hierarchy and services	Updated NCQA Factor 3 language r/t OON utilization, updated UM Committee/ QIHE Committee to QIHE/UMC- Completed 7/22/2026	X		X		Michelle Findlater	
UM	UM-003	Concurrent Review and Discharge Planning Process	This policy addresses the provision of inpatient services provided in an acute and long-term care acute inpatient settings: medical/surgical or behavioral. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.	Updated language related to UM Denial Agreement. DMHC Finding #9 verbiage update requested for alignment with agreements with treating provider prior to issuance of a denial	X				Michelle Findlater	
UM	UM-004	Over and Underutilization	To establish a systematic approach for identifying, monitoring and addressing patterns of healthcare over- and underutilization to ensure appropriate allocation of healthcare resources, improve quality of care and promote cost-effectiveness while meeting members' healthcare needs	Changed spelling throughout of Over- and Underutilization to ensure alignment. Changed all references from UMC to the combined QIHE/UMC , updated the BH policy reference	X		X		Michelle Findlater	
UM	UM-005	Second Opinions	This policy establishes guidelines for requesting, processing and documenting second opinions to promote patient-centered care and informed decision-making.	Annual Review- minor formatting updates. Aligned turn around times to UM-051. Corrected Compliance Delegation Oversight policy number and reference to QIHE/UMC.	X		X		Michelle Findlater	
UM	UM-007	New and/or Experimental Technology Review Process	established mechanism for reviewing new and/or experimental technology as well as a new application of existing technology. The intent of the evaluation of new developments in technology and new applications of existing technology is to ensure that Alliance members have equitable access to safe and effective care.	Annual Review- minor formatting updates. Reference to QIHE/UMC.	X		X		Michelle Findlater	
UM	UM-008	Coordination of Care- California Children's Services (CCS)	This Policy describes how Primary care providers (PCPs) and specialists are responsible for the early identification and referral of children with potentially eligible conditions to the California Children's Services (CCS) program, notifying Alameda Alliance's Utilization Management (UM) Unit of such referrals to ensure the delivery of medically necessary care throughout the referral process regardless of CCS eligibility status.	Updated formatting (Major), Changed to new QIHE/UMC, Added scope for CCS Age out to 17 and Delegated assessments and quarterly check ins. Removed reference to outdated CCS referral workflow. Updated Compliance Policy number	X		X		Michelle Findlater	
UM	UM-011	Coordination of Care - Hospice Services and Terminal Illness	To establish a comprehensive, compassionate and regulatory-compliant approach to hospice and terminal illness care ensuring patient dignity, comfort and appropriate medical management.	Major reformatting- alignment with the draft APL related to Auth and documentation requirements. Updated Policy alignment for Compliance and Claims. Annual Review.	X		X		Michelle Findlater	
UM	UM-014	Identifying and Reporting Potential Child, Adult or Elder Abuse	PCPs are responsible for the overall health care of assigned Members including the identification and reporting of suspected child, adult, or elder abuse cases.	Annual Review. Minor Formatting. Updated QIHE/UMC reference	X		X		Michelle Findlater	
UM	UM-023	Communicable Disease Reporting and Services	reporting of communicable diseases, and to implement directives from public health authorities.	Annual Review. Minor Formatting. Updated QIHE/UMC reference	X		X		Michelle Findlater	
UM	UM-036	Continuity of Care for Terminated and Non- Participating Providers	The Alliance provides for the completion and continuity of covered services by a terminated or out-of-network/non-participating provider (NPP) of any type at the member's request in accordance with Health and Safety Code Section 1373.96, including medical and mental health service providers.	Update the new APL Block Transfer 25-019- no language needed other than the reference. Updated various outdated definitions, added in definitions for Preclusion and Exclusion, updated all APL references to newer versions. Changed listed TATs to reference UM 051 UM Timeliness policy	X		X		Michelle Findlater	

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UM	UM-045	Communication Services - UM	To establish and maintain procedures ensuring that members have timely access to Utilization Management (UM) staff for information about the UM process, authorization of care and status of requests in accordance with DHCS and CMS regulations.	Annual Review. Minor Formatting. Updated QIHE/UMC reference, Updated references with most Up to date	X		X		Michelle Findlater	
UM	UM-046	Use of Board-Certified Consultants	To establish standards governing the use of Board-Certified Consultants and other qualified clinical reviewers in utilization management activities to ensure medical necessity determinations, organizational determinations, and appeals are based on appropriate clinical expertise and comply with Medi-Cal Managed Care, Medicare Advantage (D-SNP), DHCS, CMS, and NCQA requirements.	Updated language related to Board Certified consultant roles in appeals, conflicts of interest, Peer-to- peer. Added more references and aligned with the QIHE/UMC terminology.	X		X		Michelle Findlater	
UM	UM-048	Triage & Screening Services	Alameda Alliance for Health ("Alliance") arranges for triage and screening services available by telephone to members 24 hours per day, 7 days per week. The plan establishes a consistent, effective, and compliant approach to patient triage and screening. Telephone triage or screening services are provided in a timely manner appropriate for the requesting member's condition.	Updated language related to BH service availability, unlicensed staff roles and responsibilities, availability of information for members and providers and updates the reference sections.	X		X		Michelle Findlater	
UM	UM-050	Tracking and Monitoring of Services Prior Authorized	This policy establishes procedures for the systematic tracking and monitoring of healthcare services subject to prior authorization (PA) requirements. It ensures compliance with CMS and Medicaid services regulations for PA and safeguards against improper utilization.	Updates for the QIHE/UMC references. Enhancements for the Interoperability data submissions requirements. Enhances language for Delegation Oversite monitoring. Added enhanced language related to health equity monitoring. Added reference documents.	X		X		Michelle Findlater	
UM	UM-051	Timeliness of UM Decision Making and Notification	Alameda Alliance will meet all applicable state and federal timely decision-making regulations, based in whole or in part on medical necessity in determining whether to approve, modify, or deny requests by providers.	DMHC #9 Follow up Updated language related to knox keene definition and clarified the 24 hours per DMHC request	X				Michelle Findlater	
UM	UM-055	Palliative Care	This policy establishes guidelines for the provision of palliative care services in alignment with Medicare and Medicaid services (CMS)	Annual Review. Minor updates to references, and clarified D-SNP language about payor.	X		X		Michelle Findlater	
UM	UM-057	Authorization Service Request	current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.	Added Exclusion, preclusion & termination language, clarified non-clinical denial scope language, minor formatting, grammar, references and affiliated policies updated, added language to clarify there are no compensation or performance evaluations based on denials reductions or limitations of services. Change P2P to business day from same day. Removed language that Bedholds & Leaves of absence require an auth	X				Michelle Findlater	
UM	UM-058	Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving a Medical Exemption	This policy establishes guidelines and procedures for ensuring continuity of care for Dual Special Needs Plan (D-SNP) and Medi-Cal plans who have Medical Exempt Requests (MER). This policy ensures compliance with federal and state regulations governing continuity of care while facilitating smooth transitions for members with complex medical conditions.	Annual update. Changed beneficiary to member throughout. Updated APL reference.	X		X		Michelle Findlater	

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UM	UM-070	UM Information Integrity	maintaining and safeguarding information used in the Utilization Management (UM) decision-making and denial notification processes to ensure accuracy, completeness, readability, and protection against unauthorized or inappropriate modification.	Updated title of policy to better align with NCQA requirements, strengthened audit language, corrected dept titles. Reworded policy statement	X				Michelle Findlater	
UM	UM-D-001	Prior Authorization/Concurrent Review/Organization Determination Audit Process Policy (RGR)	This policy establishes a standardized audit process to evaluate the accuracy, timeliness, and compliance of these activities, promoting high-quality care and adherence to CMS and DHCS requirements.	Annual Review. Minor grammar updates. Changed the audit cadence from monthly to quarterly due to volume limitations at this time.	X				Michelle Findlater	
UM	UM-D-003	Readmission Review Policy	The Readmission Review Policy establishes a process to evaluate readmissions for members, ensure medical necessity, optimize resource utilization, and reduce potentially preventable readmissions (PPRs).	Refined language for the CM referrals. Annual Review	X		X		Michelle Findlater	
UM	UM-D-007	New and/or Experimental Technology Review Process	established mechanism for reviewing new and/or experimental technology as well as a new application of existing technology	Updated QIHE/UMC references. And Compliance policy reference.	X		X		Michelle Findlater	
QI		NCQA Accreditation Process	This policy establishes a standardized process for planning, managing, documenting, and maintaining accreditation readiness and compliance with applicable National Committee for Quality Assurance (NCQA) standards.	MCAL, IHSS	New		X		Eileen Ahn	

POLICY AND PROCEDURE

Policy Number	QI-107
Policy Name	Appointment 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, D-SNP
Effective Date	3/31/2016
Administrative Oversight Committee Approval Date	9/17/2025

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") and Alameda Alliance for Wellness (D-SNP))the Alliance) complies with the access and availability regulatory and contractual requirements of the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA).

The Alliance shall implement and maintain procedures for members to obtain appointments for routine (non-urgent) and urgent care for all applicable provider types, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Access and availability procedures will also include procedures for follow-up on missed appointments. Alliance practitioners and medical groups, including primary care providers (PCPs), obstetrics or gynecology (OB/GYN) practitioners, are required to meet the access standards delineated below to participate in the Alliance network. Providers contracted with the Alliance are responsible for providing access to care for members twenty-four (24) hours per day, seven (7) days a week. All delegated medical groups, including contracted behavioral health providers, are required to provide or ensure that twenty-four (24) hours per day, seven (7) days a week access to medical care for members is available, including after business hours telephone access to a physician or a triage system utilizing specific licensed practitioners.

The Alliance ensures ongoing oversight and monitoring of its provider network through the Access and Availability (A&A) Committee. Quality Improvement (QI) staff will engage in any

of the following actions with providers failing to meet the access and availability standards set within this policy:

A. Provider education/re-education and outreach (face-to-face, verbal, and/or written)
B. Written corrective action plans (CAPs)
C. Resurveying within a specified timeframe to assess/reassess compliance with timely access standard(s)
D. Discussions at Joint Operations Meetings (for delegates)
E. Referral to the A&A Committee for discussion and recommendations for next steps
F. Referral to the Credentialing Committee (CC), and/or to the Peer Review and Credentialing Committee (PRCC) as appropriate, for discussion and recommendations for next steps
G. Referral to the Chief Operating Officer (COO) and Chief Financial Officer (CFO) for discussion and recommendations for next steps (for delegates)
H. Other actions as appropriate

PROCEDURE

A. Appointment Access Standards

Please refer to the table below for the access and availability regulatory and contractual requirements, per DMHC and DHCS regulations.

Life-Threatening Emergency:

- Immediately, twenty-four (24) hours a day, seven (7) days a week

A life-threatening emergency is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- A patient's health being placed in serious jeopardy
- Serious impairment of bodily function
- Serious dysfunction of any bodily organ or part

Non-Life-Threatening Emergency

- Within six (6) hours of the request

The Alliance communicates appointment access standards to providers through the Alliance Provider Manual, during orientation training for new providers, through Provider Bulletins, through quarterly provider packets, and through fax blasts.

APPOINTMENTS WAIT TIMES (MCAL)	
Appointment Type:	**Appointment Within:**

Urgent Appointment that *does not* require PA	48 Hours of the Request
Urgent Appointment that *requires* PA[1]	96 Hours of the Request
Non-Urgent **Primary Care** Appointment	10 Business Days of the Request
First Prenatal Visit	2 Weeks of the Request
Non-Urgent **Specialist** Appointment	15 Business Days of the Request
Non-Urgent **Behavioral Health** Appointment	10 Business Days of the Request
Non-Urgent Appointment for **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days of the Request
APPOINTMENTS WAIT TIME (D-SNP)	
Appointment Type:	**Appointment Within:**
Urgently needed services or emergency that does not require PA	Immediately
Non-Urgent Primary Care Appointment	7 Business Days of Request
Routine or preventive care	30 Business Days of Request

[1] Prior authorization

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Standard:	**Within:**
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure Proper Emergency Instructions	
Language Services – Provide 24 Hour Interpretive Services	

B. LTSS Timely Access Network Standards

The Alliance's Utilization Management Department monitors our LTSS facility against the following timely access network standards

LTSS TIMELY ACCESS NETWORK STANDARDS	
Provider Type:	**Standard:**
Skill Nursing Facility	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 5 business days of request
Community Based Adult Services (CBAS)	

Initial	Within 5 business days acknowledge receipt of request from CBAS center
F2F Eligibility Assessment	Completed within 30 days
IPC by CBAS Center	Within 90 days
Reassessment	6 months
Hospice	
Hospice Care Services	Within 24 hours of request

*****The DMHC Timely Access standard is 15 Business days for Psychiatrists; however, to comply with the CMS and NCQA accreditation standards of 10 Business days, Alliance uses the more stringent standards.

C. Shortening or Extending Appointment Timeframes
The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's medical record that a longer waiting time will not have a detrimental impact on the health of the Member.

D. Telephone Access Standards – For the Plan
During normal business hours, the wait time for members to speak by telephone with an Alliance Member Services representative knowledgeable and competent in addressing members questions and concerns shall not exceed ten (10) minutes.

E. Telephone Access Standards – For the **Provider Office**
During normal business hours, the wait time for members to speak by telephone with a provider staff member knowledgeable and competent in addressing members' questions and concerns shall not exceed ten (10) minutes.

Providers comply with the standards for responding to members phone calls by ensuring:

A. Appropriate personnel handle emergent, urgent, and medical advice telephone calls,
B. The telephone answering machine, voicemail system, or answering service is used whenever office staff does not directly answer phone calls, and
C. The telephone system answering service, recorded telephone information, or recording device are periodically checked and updated.

F. After Hours Access to Primary Care Providers (PCPs), Specialists and Behavioral Health Providers

The Alliance requires that PCPs, specialists, and behavioral health providers have arrangements in place for telephone access twenty-four (24) hours per day, seven (7) days per week, per CMS and DHCS regulatory requirements. Providers are required to meet minimum standards for access to after- hours care by including the following information in their after-hours message:

- Identification of provider's name,
- Information regarding office hours,
- Instructions on what to do in a medical emergency,
- Option to leave a message for the provider, and
- The anticipated length of wait time for a return call from the provider.

The waiting time for PCP, specialist, and behavioral health provider telephone triage or screening shall not exceed thirty (30) minutes, during **and** after normal business hours.

The Alliance, in conjunction with its survey vendor, annually conducts an after-hours survey to monitor provider compliance with after-hours care. Providers who may be excused from the After- Hours survey include:

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

G. Missed Appointments

When a member's scheduled appointment is missed, Alliance providers must follow-up with the member to schedule another appointment based on the initial type of care required (e.g., urgent, routine, preventive, prenatal, etc.).

Alliance providers must have a process in place to follow up on missed or canceled appointments that includes the following at a minimum:

1. Documentation of the missed or canceled appointment in the member's medical record.
2. Review of the potential impact of the missed or canceled appointment on the member's health status, including review of the reason for the appointment by a licensed staff member of the provider's office. (RN, PA, NP, or MD).

3. Documentation in the medical record describing the follow up for the missed or canceled appointment, including one of the following actions: no action if there is no effect on the member due to the missed appointment; or a letter or phone call to the member as appropriate, given the type of appointment missed and the potential impact on the member. The medical record entry must be signed or co-signed by the member's assigned PCP or covering physician/provider.
4. Three (3) attempts, at least one (1) by phone and one (1) by mail, made in attempting to contact a member if the member's health status is potentially at significant risk due to missed or canceled appointments. Examples include members with serious chronic illnesses, members with test results that are significant (e.g., abnormal Pap smear), and treating provider's judgement to be at risk for other reasons. Documentation of the attempts must be entered in the member's medical record and copies of letters retained.
5. Office staff in Alliance provider offices that are trained in, and familiar with, the missed or canceled appointment procedure specific to their site.

The Alliance monitors missed, canceled, and rescheduled appointments through facility site review (FSR) and medical record review (MRR) evaluations.

H. Emergency Services

The Alliance has continuous availability, accessibility, as well as adequate numbers of

a) institutional facilities,
b) service locations,
c) service sites,
d) professional allied, and
e) supportive paramedical personnel

to provide covered services including the provision of all medical care necessary under emergency circumstances. The Alliance network of physicians and hospitals are required to provide access to appropriate triage personnel and emergency services twenty-four (24) hours per day, seven (7) days a week.

The Alliance will include covered ambulance services for the area served by the plan to transport the member to the nearest twenty-four (24) hour emergency facility with physician coverage, designated by the Alliance. The Alliance evaluates inappropriate use of emergency room services, issues regarding member access to health care, and under- or over-utilization of services through:

a) assessment of encounter data,
b) special studies,
c) claims data,
d) grievances and appeals,
e) Potential Quality Issues (PQIs)
f) medical record audits, and
g) medical oversight of the Quality Improvement Health Equity/Utilization Management Committee (QIHE/UMC).

I. Follow-up of Emergency Room or Urgent Care Visits
Hospitals and medical groups are responsible for informing PCPs of members that receive an emergency room (ER) or urgent care visit including information regarding needed follow-up, as needed. PCPs are responsible for obtaining necessary medical records from an ER or urgent care visit and arranging any needed follow-up care.

J. Open Access to OB/GYN Services
In accordance with state law, the Alliance requires that all practitioners and medical groups allow women direct access without referral for OB/GYN services to a participating OB/GYN or Family Practitioner (FP) that meets Alliance credentialing standards.

The Alliance requires members to obtain direct access only from those OB/GYNs or FPs within the group or Alliance network to which they are assigned, and to use contracted/assigned hospitals for facility-based services.

The Alliance requires OB/GYNs or FPs to follow prior authorization guidelines for any specialized procedures or other treatments outside of a "well woman" exam or routine OB/GYN care. The Alliance requires OB/GYNs or FPs to communicate with the member's PCP regarding the member's condition, treatment, and follow-up care.

K. Access to Sensitive Services for Adults
Providers and practitioners must have procedures in place to ensure that adults have access to sensitive and confidential services. Sensitive services do not require prior authorization and can be obtained by out-of-network providers.

L. Access to Sensitive Services for Minors
Minors and adolescents have the right to consent to and receive sensitive services without parental consent. Sensitive services do not require prior authorization and can be obtained by out-of- network providers.

Alliance members aged 12-21 may access sensitive services through their PCP, or through other network physicians within the medical group or Alliance network, and in the case of certain services for Medi-Cal Members, any qualified practitioner (See UM-029 for prior authorization details).

a) Sensitive services may include, but are not limited to, the following:
    i. Treatment for sexual assault, including rape.
    ii. Pregnancy related services.
    iii. Family planning services.
    iv. Sexually transmitted disease diagnosis and/or treatment.
    v. HIV testing and counseling.
    vi. Abortion services
b) Members are bound by the rules or procedures required for the specific services they are accessing.

c) Members are informed of their rights to access sensitive services through the Member Handbook

DEFINITIONS / ACRONYMS

Appointment waiting time – The time from the initial request to the plan or a provider for covered health care services by an enrollee, an enrollee's representative or the enrollee's treating provider to the earliest date offered for the appointment for services. Appointment waiting time is inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its network providers. A grievance, as defined in Rule 1300.68(a)(1), regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered healthcare services...

Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule – A schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence for preventive pediatric health care **(www.aap.org/en**https://www.aap.org/en-us/Documents/periodicity_schedule.pdf**us/Documents/periodicity_schedule.pdf).**

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.

Non-urgent care – Routine appointments for non-urgent conditions.

Preventive care – Health care provided for prevention and early detection of disease, illness, injury, or other health conditions and, in the case of a full-service plan includes all of the following health care services required by sections 1345(b)(5),1367.002, 1367.3 and 1367.35 of the Knox-Keene Act, and Rule 1300.67(f).

Provider - Physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.

Triage or screening - The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

Triage or screening waiting time - The time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.

Urgent care – Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Routine or preventive care – routine (or regular) health care that includes cancer screening, vaccines, check-ups, and patient counseling to prevent illness, disease, or other health problems (i.e., annual wellness, welcome to Medicare).

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

UM-029 Sensitive Services
UM-048 Triage and Screening Services
PRV-003 Provider Network Capacity Standards
QI-104 Potential Quality Issues
QI-105 Primary Care Provider Site Reviews
QI-108 Access to Behavioral Health Services
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee
QI-116 Provider Appointment Availability Survey
CLS-003 Language Assistance Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

After-Hours Survey Tool
Facility Site Review Tool
Medical Record Review Tool
Provider Appointment Availability Survey
Tool Alliance Timely Access Standards

REVISION HISTORY

3/31/2016, 3/1/2018, 7/19/2018, 1/17/2019, 3/2120/19, 3/19/2020, 11/23/2021, 6/28/2022, 03/21/2023, 05/02/2023,9/19/2023, 12/19/2023, 6/12/2024, 12/18/2024, 9/17/2025

REFERENCES

DHCS Contract Exhibit A, Attachment 9, Access and Availability Title 28, CCR, Section 1300.67.2.2(c)(8)(A)(B)
DHCS Contract Exhibit A, Attachment 10, Scope of Services
Title 28, CCR, Section 1300.80 Medical Survey Procedures
DHCS All Plan Letter 15-020 Abortion Services
DHCS All Plan Letter 21-006 Network Certification Requirements
NCQA 2020 Standards and Guidelines for the Accreditation of Health Plans, Net 2: Accessibility of Services
DMHC Provider Appointment Availability Survey Methodology Measurement Year 2020
42 CFR 422.112 - Access to Service
Medicare Managed Care Manual

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/Utilization Management Committee (QIHE/UMC) annually for review and feedback. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.

POLICY AND PROCEDURE

Policy Number	QI-108
Policy Name	Access to Behavioral Health Services
Department Name	Quality Improvement Division
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	3/31/2015
Administrative Oversight Committee Approval Date	9/17/2025

POLICY STATEMENT

Alameda Alliance for Health (Alliance) and Alameda Alliance for Wellness (D-SNP) the Alliance ensures its provider network is sufficient to provide accessibility, availability, and continuity of covered behavioral health services, per the regulatory and contractual requirements of the Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA).

The mental health services required for the diagnosis and treatment of conditions shall include, when medically necessary, all health care services required but not limited to basic health care services within the California Code, Health and Safety Code, Sections 1345 (b) and 1367 (i), and Title 28, California Code of Regulations (CCR), Section 1300.67. These basic health care services include, at a minimum: physician services, including consultation and referral; hospital inpatient services and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; emergency health care services, including ambulance and ambulance transport services and out-of-area coverage; and hospice care pursuant to Section 1368.2.

PROCEDURE

The Alliance complies with the access and availability standards set by CMS, DMHC and DHCS. The required access and availability standards below are applicable to behavioral health services provided by the Alliance.

A. Behavioral Health Access Standards:

I. Life-Threatening Emergency
Immediately, twenty-four (24) hours a day, seven (7) days a week
A life-threatening emergency is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

A. A patient's health being placed in serious jeopardy
B. Serious impairment of bodily function
C. Serious dysfunction of any bodily organ or part

II. Non-Life-Threatening Emergency
Within six (6) hours of the request

III. Urgent Behavioral Health (BH) Care by Non-Physician Mental Health (NPMH) Provider
Within forty-eight (48) hours of the request
Requiring Prior Authorization, within ninety-six (96) hours of the request

IV. Non-Urgent BH Care by NPMH Provider
Within ten (10) business days of the request

V. After-Hours Access
Twenty-four (24) hours a day, seven (7) days a week access to BH care including after business hours telephone access to a triage system

VI. After-Hours Emergency Instructions
Availability of instructions for how members may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone

VII. Telephone Triage and Screening
Twenty-four (24) hours a day, seven (7) days a week, for triage or screening services by telephone. The telephone triage or screening services are provided in a timely manner appropriate for the member's condition, with a wait time that does not exceed thirty (30) minutes. Unlicensed staff persons handling member calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of the member so that the member can be referred to licensed staff. However, under no circumstances shall unlicensed staff persons use the answers to those questions in an

attempt to assess, evaluate, advise, or make any decision regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional.

B. Member Information Distribution

The Alliance distributes Evidence of Coverage (EOC) material to each member upon enrollment and annually thereafter, which explains how to obtain mental health services. Member materials include information on how to obtain routine mental health services, after hours services, or how to obtain urgent and emergency mental health services. The Alliance's EOC clearly describes the mental health benefit and coverage information for mental health conditions. The Alliance includes the telephone number on the member's ID card that members can call to obtain information regarding mental health benefits, providers, coverage, and any other member relevant information. The Alliance's website also includes detailed information on the mental health benefit and how to obtain services.

C. Monitoring of Behavioral Health Access Standards

Monitoring of behavioral health care services is conducted through various quality improvement activities including but not limited to: provider access and availability surveys, quarterly geo-access reports, member satisfaction surveys, grievance and appeals data, member complaint logs, care coordination data, and network reported data. Information, data and reports are discussed at the Alliance's Access and Availability (A&A) Committee for review and identification of opportunities for improvement, issuance of corrective action plans (CAPs) and other recommendations. A&A Committee minutes are reported up to the Quality Improvement Health Equity/Utilization Management Committee (QIHE/UMC) which can make additional recommendations.

The Alliance will issue CAPs to the delegated entity for mental health services and require responses within thirty (30) calendar days of notice. If the delegate fails to submit a timely response addressing the corrective actions, the Alliance may take disciplinary actions. Depending on the severity of the deficiency, the Alliance may choose to freeze new membership to the delegate or pursue terminating the delegation contract.

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DEFINITIONS / ACRONYMS

Corrective Actions – Specific identifiable activities or undertakings of the health plan that address program deficiencies or problems and that request responses to correct those deficiencies or problems.

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

Department of Health Care Services (DHCS) – The single State Department responsible for administration of the federal Medicaid/Medi-Cal (in CA) program.

Department of Managed Health Care (DMHC) – The State agency responsible for administering the Knox-Keene Health Care Services Plan Act of 1975.

Triage or screening - The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

Triage or screening waiting time - The time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

PRV-003 Provider Network Capacity Standards
QI-107 Appointment Access and Availability Standards
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee
QI-116 Provider Appointment Availability Survey (PAAS)
QI-117 Member Satisfaction Survey (CAHPS)
QI-118 Provider Satisfaction Survey
UM-048 Triage and Screening Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

DMHC Provider Appointment Availability Survey Tools (PCP, Specialist, NPMH, Ancillary) After Hours Survey Tool

REVISION HISTORY

3/31/15, 3/24/16, 2/16/17, 5/3/18, 3/15/19, 3/19/20, 11/23/2021, 03/21/2023, 6/12/2024, 9/18/2024, 9/17/2025

REFERENCES

California Code, Health and Safety Code, Sections 1345 (b), 1367 (i), and 1368.2
DHCS Contract, Exhibit A, Attachment 9, Access and Availability
Title 28, CCR, Sections 1300.67, 1300.67.2
DHCS All Plan Letter 21-006 Network Certification Requirements
DMHC Provider Appointment Availability Survey Methodology Measurement Year 2019
NCQA 2020 Standards and Guidelines for the Accreditation of
Health Plans, Net 2: Accessibility of Services
42 CFR 422.112 Access to Services
CMS Managed Care Manual

MONITORING

Access to behavioral health services is monitored in the following ways: 1) annually by Compliance through delegation oversight activities; 2) annually by Quality Improvement through the Provider Appointment Availability Survey; 3) quarterly by Quality Improvement through the A&A Committee; and by Compliance and/or Quality Improvement on an ad-hoc basis through other reporting and/or data collection processes. This policy is reviewed and updated annually to ensure it is effective and meets regulatory and contractual requirements.

POLICY AND PROCEDURE TEMPLATE

Policy Number	QI-116
Policy Name	Provider Appointment Availability Survey (PAAS)
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	3/31/2016
Administrative Oversight Committee Approval Date	9/17/2025

POLICY STATEMENT

Alameda Alliance for Health and Alameda Alliance Wellness ("Alliance") e conducts an annual Provider Appointment Availability Survey (PAAS) in accordance with the Department of Managed Health Care (DMHC) survey methodology. The survey is designed to monitor Alliance delegated and directly contracted provider compliance with access and availability standards for Alliance members, including:

1. Ensuring members timely access to and availability of covered quality health care services that are appropriate for their patients' condition.
2. Establishing and maintaining a provider network, policies and procedures, and quality assurance that ensure compliance with clinically appropriate standards.
3. Maintaining efficient processes necessary for members to obtain covered services as appropriate (e.g., referral and prior authorization process); and
4. Maintaining a system to ensure members are seen in a timely manner.

PROCEDURE

A. Provider Appointment Availability Survey (PAAS) Methodology

1) The Alliance conducts the PAAS to measure provider compliance with DMHC access and availability standards in accordance with the current DMHC PAAS methodology.
2) Dependent upon provider type, the Alliance uses one of five DMHC-developed survey tools: the primary care provider (PCP) Survey Tool, the Specialist Provider Survey Tool, the Psychiatrist Survey Tool, the Non-Physician Mental Health (NPMH) Provider Survey Tool; and the Ancillary Provider Survey Tool.
3) The Alliance Analytics Department selects a random sample of providers from its provider network based on criteria set forth in the DMHC PAAS methodology. While DMHC PAAS methodology may change each year, the samples selected include the following:
    i. PCPs: Primary Care Physicians and Non-Physician Medical Practitioners providing primary care
    ii. Specialist Physicians: Cardiovascular Disease, Endocrinology, ~~and~~ Gastroenterology, Dermatology, Neurology, Oncology, Ophthalmology, Otolaryngology, Pulmonology, and Urology
    iii. Psychiatrists
    iv. NPMH Providers: Licensed Professional Clinical Counselor (LPCC), Psychologist (PhD-Level), Marriage and Family Therapist/Licensed Marriage and Family Therapist and Master of Social Work/Licensed Clinical Social Worker
    v. Ancillary Service Providers: Facilities or entities providing mammogram or physical therapy appointments

4) The survey questions cover appointment availability standards:
    a. PCPs
        i. Urgent appointments (within 48 hours of request)
        ii. Routine appointments (within 10 business days of request)
    b. Specialists
        i. Urgent appointment (within 48~~96~~ hours of request/within 96 hours of request that requires PA)
        ii. Routine appointment (within 15 business days of request)
    c. Psychiatrists
        i. Urgent appointments (within 48~~96~~ hours of request/within 96 hours of request that requires PA)
        ii. Routine appointments (within 15 business days of request)
    d. NPMH Providers
        i. Urgent appointments (within 48~~96~~ hours of request/within 96 hours of request that requires PA)
        ii. Routine appointments (within 10 business days of request)
        iii. Follow-up non-urgent appointments (within 10 business days of the prior appointment)

e. Ancillary Service Providers
i. Routine appointments (within 15 business days of request)
f. Appointments Wait Time for D-SNP
i. Urgently needed services or emergency that does not require PA (Immediately)
ii. Non-Urgent primary care appointments (7 business days of request)
iii. Routine or preventive care (30 business days of request)

B. PAAS Analysis and Report

1) Designated Quality Improvement (QI) staff report the qualitative and quantitative results of the PAAS for review and recommendations to the Access and Availability (A&A) Committee.
2) The PAAS results, conclusions and recommendations are then reported to the Quality Improvement Health Equity/Utilization Management Committee (QIHE/UMC) for feedback and approval.
3) Delegated and directly contracted providers and groups are notified of the results of the PAAS with aggregate compliance rates.
   i. Providers, groups, and delegates found non-compliant with the standards are issued a corrective action plan (CAP) and are re-educated on the DMHC's appointment availability standards.
   ii. Providers, groups, and delegates found non-responsive to the survey are issued a CAP and are re-educated on the DMHC's appointment availability standards.
4) PAAS results, conclusions and recommendations are incorporated into the annual QI Program Evaluation and QI Program Work Plan for the upcoming year. The QI Program Evaluation is reported annually to the Department of Health Care Services (DHCS).
5) The Senior Director of Quality continuously monitors, tracks, and analyzes access and availability rates, continuity of care, and utilization satisfaction indicators to detect incidents, trends, and patterns of dissatisfaction with its provider network. QI staff analyze the data to identify opportunities for improvement with:
   i. Systemic operations issues/problems
   ii. Complaint types and resolutions; and/or
   iii. Member identified needs

DEFINITIONS / ACRONYMS

Patterns of Non-Compliance means any of the following:

(A) For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers and 80% for NPMH provider follow-up appointments, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific net had a non-urgent or urgent appointment available within the time-elapsed standards set forth in subsection (c)(5)(A)-(F) for the measurement year. A pattern of non-compliance shall be identified using the information reported to the Department in the "Rate of Compliance Urgent Care Appointment (All Provider Survey Types) field and the "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)" field in the Summary of Rate of Compliance Tab of the Results Report Form.

(B) The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees. The Department may consider any of the following factors in evaluating whether each instance identified is part of noncompliance that is reasonably related:

i. Each instance is a violation of the same standard set forth in subsection (c) of this Rule;

ii. Each instance involves the same network;

a. Each instance involves the same provider group, or subcontracted plan;
b. Each instance involves the same provider type;
c. Each instance involves the same network provider;
d. Each instance occurs in the same region. For purposes of the subsection, a region is a county in which a network provider practices, and the counties next to or adjoining that county;
e. The number of enrollees in health plan's network and the total number of instances identified as part of a pattern;
f. Whether each instance occurred within the same twelve-month period; or
g. Whether each instance involves the same category of health care services.

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.

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AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Program
QI-104 Potential Quality Issues (PQIs)
QI-105 FSRs MRRs and PARS
QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-114 Monitoring of Access and Availability Standards
QI-116 Provider Appointment Availability Survey

QI-115 Access and Availability Committee
QI-117 Member Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

QI Program Evaluation
QI Work Plan
DMHC PAAS Survey Tools (PCP, Specialist, Psychiatrist, NPMH, Ancillary)

REVISION APPROVAL HISTORY

3/31/2016, 3/9/2017, 3/01/2018, 01/17/2019, 5/16/2019, 3/19/2020, 05/20/2021, 06/28/2022, 03/21/2023, 6/12/2024, **12/18/2024**, **9/17/2025**

Blue = Material Changes

REFERENCES

DMHC PAAS Methodology, Measurement Year 2019
DMHC All Plan Letter 19-008 Timely Access Compliance Reports Measurement Year 2019

MONITORING

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

POLICY AND PROCEDURE

Policy Number	HED-001
Policy Name	Health Education Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, DSNP
Effective Date	11/21/2006
Administrative Oversight Committee Approval Date	TBD~~11/19/2025~~

POLICY STATEMENT

Alameda Alliance for Health and Alameda Alliance Wellness (D-SNP) (the Alliance) maintains a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion, and patient education for all members. The health education program has administrative oversight by qualified staff and establishes priorities based on population assessment and quality improvement plans. The program implements evidence-based interventions and appropriate evaluation of programs. The Alliance maintains health education policies and procedures that comply with contracts, policy letters, and accepted guidelines and standards.

PROCEDURE

1. The Director of Population Health and Equity (PHE) provides operational oversight and leadership for Alameda Alliance for Health's population health assessments, strategy and evaluation. The PHE Director is also responsible for state and federal regulatory and accreditation requirements concerning Population Health, Cultural and Linguistic Services and member Health Education. In addition, the PHE Director will support health equity initiatives for Stars, by aligning these efforts with broader organizational goals. This position reports to the Senior Director of Quality Improvement ~~and works closely with the Chief of Health Equity~~. The Population Health and Equity Director at the Alliance provides administrative oversight of the Health Education Program. It is a full-time position held by a health educator with a master's degree in public health or community health, with a

specialization in health education. The Population Health and Equity Director is a member of the Health Care Services Department and specifically is a part of the Quality Improvement team to ensure coordination and integration.

2. The Alliance provides evidence-based health education programs to all members.
   2.1. The Health Education Program aligns health education interventions for addressing health categories and topics within Population Health Management.
   2.2. The Alliance uses ~~Population Needs Assessment (PNA)~~ Local Planning findings (Community Health Needs Assessments and Community Health Improvement Programs), HEDIS results, Star measure performance, and other internal and external data sources, to inform its program priorities, target populations, levels of intervention, and the development of the annual work plan, including program goals and objectives.
   2.3. Health Education updates its program goals, objectives, activities, and resource needs annually.

3. The Alliance ensures the organized delivery of health education programs using education strategies and methods appropriate for members and effective in achieving behavioral change. This is accomplished through:
   3.1.1. Review of relevant literature, evidence-based interventions, and best practices
   3.1.2. Offering accredited programs
   3.1.3. Evaluating health education programs

4. The Alliance may offer non-monetary incentives for participating in incentive programs, focus groups and member surveys as authorized by W&I Code section 144.07.1 pursuant to APL 16-005.

5. Alliance health education programs and services are also reviewed through regular audits to ensure they meet the cultural and linguistic needs of members and follow health literacy standards, including sixth-grade or lower reading level. Translation services and alternative formats are available for health education materials for all members upon request at no charge to the member.

6. Alliance health education programs and services are provided at no charge to members and are delivered by the plan directly or through agreements with organizations embedded within member communities noted for expertise in delivering health education programs. The Alliance maintains listings of the no cost community health education program referrals available to members and promotes health education opportunities through our website and member newsletter.

7. The Alliance health education program covers the following program interventions:

7.1. **Appropriate Use of Managed Health Care Services** including preventive and primary health care services, obstetrical care, health education services and appropriate use of complementary and alternative care.

7.2. **Risk Reduction and Healthy Lifestyles** including, but not limited to programs for tobacco use and cessation; alcohol and drug use; injury prevention, nutrition and physical activity.

7.2.1. Member confidentiality regarding family planning, gender identity, sexual orientation, and alcohol and substance use is protected.

7.2.2. The CDC's Diabetes Prevention Program (DPP) and Medicare Diabetes Prevention Program (MDPP) are available for members meeting CDC criteria (*see HED-009 for details*). While the CDC sets the curriculum for both, CMS determines the specific participant and supplier eligibility criteria for the MDPP.

7.3. **Self-Care and Management of Health Conditions** including but not limited to pregnancy, asthma, diabetes, and hypertension.

7.4. **Breastfeeding promotion, education, and counseling** services to pregnant and lactating members.

7.4.1. Prenatal and postpartum mailings to all identified birthing members~~Alliance moms~~ with information on the benefits of breastfeeding, doula services, and referral to Women Infants and Children (WIC).

7.4.2. Eligible members are referred to WIC.

7.4.3. Coordination with community agencies and referrals to ensure that postpartum women receive breastfeeding counseling and support after delivery.

7.4.4. International Board-Certified Breastfeeding Consultants (IBCLC) are available to Alliance members by phone or for in-person visits. Services are provided under a supervising licensed provider.

8. Members may access the Alliance Health Education programs upon self-referral or provider referral. The Alliance conducts outreach to maximize members' participation in programs. Health Education staff connects members with services and programs through the following activities:

8.1. Explaining the effective use of health care services and availability of health education programs in the Member Handbook (Evidence of Coverage).

8.2. Placement of health education articles in member newsletter distributed two (2) times a year.

8.3. Maintaining a library of health education ~~handouts~~ topics and articles covering health topics listed in Alliance program interventions above, topics that align to the Population Health Management Strategy, and topics specific to the needs of our members. ~~Handouts~~ Health Education topics and articles are available on-line and are mailed out to members upon request. Members and providers can mail or fax in the Wellness Request form, complete the form in the online provider portal, access the online Live Healthy Library at https://alamedaalliance.org/live-healthy/live-healthy-library/, or call Health Education to make a request. Distribution of health education materials is documented in Alliance data systems as a member's Health Education c~~C~~ase when not accessed online.

8.4. Maintaining contracts and relationships with community organizations that provide classes, support groups and self-management programs to Alliance members at no cost.

8.5. Responding to member inquiries to the Health Education Program with information on health education program offerings, facilitate referrals and document referral and class/program completion in Alliance data systems as a Health Education c~~C~~ase.

8.5.1. All referrals are documented, and class completion is documented for programs paid for by the Alliance.

8.5.2. Health Education c~~C~~ases are closed after 4 months of non-activity.

8.6. Sending targeted mailings to members with specific health conditions. Mailings include health education materials, condition self-management tools and information on self-management programs and classes that are no cost to members.

9. The Alliance ensures that members receive point of services education as a part of preventive and primary health care visits. Supports for providers include:

9.1. On-line health education materials in threshold languages and culturally appropriate health education resources and referrals that can be shared with members.

9.2. A provider health education listing of health referrals available to Alliance members.

9.3. *Provider Wellness Request Form* available for download or through the Alliance

9.4. Provider Portal to request Alliance health education programs and materials for members.

9.5. Provider communication, training, and education regarding delivery of health education services through provider quarterly packets and Alliance website resources.

10. The Alliance ensures the availability of Community Health Workers (CHWs) for members to assist members with health care system navigation, communicating cultural and language preferences to providers, accessing health care services, educating health needs, and connecting individuals and families with community-based resources. See Alliance Policy ~~*PH-004 Community Health Worker Services*~~*CHS-01 Community Health Worker Services* for details.

11. The Alliance educates providers so that health education takes place at medical and non-medical key points of service contacts as part of prevention and primary health care visits. The Alliance also offers provider education and training on the PNA findings, techniques to improve provider/patient interaction, educational and staff resources, plan-specific resources and referrals and health education requirements and monitoring. Provider training regarding health education occurs through the following methods:

    11.1. Making available to the provider a resource directory of health education, self-management supports, community programs and ancillary services free to members. This list is available on the provider pages of the Alliance website (https://alamedaalliance.org/providers/).
    11.2. Information on accessing health education resources is included in the New Provider Orientation and Provider Manual.
    11.3. Alliance website Provider section Patient Health and Wellness Education. Providers are informed of how to access website resources during their orientation and in the Provider Manual.
    11.4. Informational handouts and community-based or governmental training opportunities are shared at Provider Services during periodic office visits, website postings, and/or distributed by email or fax blast.

12. The health education program conducts appropriate levels of evaluation to ensure effectiveness and monitors performance of providers that are contracted to deliver health education programs.

    12.1. The health education program conducts formative, process, impact, and outcome evaluations as appropriate to ensure effectiveness and monitors the performance of providers that are contracted to deliver health education programs. Opportunities for improvement will be identified and appropriate activities implemented. The Health Education Program will be reviewed annually to ensure appropriate allocation of resources based on assessment and evaluation findings and other plan data. Health education accomplishes program evaluation through:
    12.2. Utilization of a case management database and automated quarterly reports to track and monitor member requests for materials and participation in health education activities. Utilization is tracked by threshold language to ensure accessibility for Limited English Proficient (LEP) members.
    12.3. Reviewing Alliance program satisfaction surveys and/or collection of survey information from contracting providers.
    12.4. Monitoring of providers contracted to deliver health education services through site visits, an audit tool, and materials review. Issues of concern are addressed, and support is provided as needed to meet Alliance standards.

12.5. Collecting and analysis of data to identify changes in behavior, confidence, health status or cost depending on the specific program objectives and available data.

DEFINITIONS / ACRONYMS

CDC – Centers for Disease Control and Prevention
CHW – Community Health Worker
DPP – Diabetes Prevention Program
HED – Health Education
HEDIS – Healthcare Effectiveness Data and Information Set
HIV - Human immunodeficiency virus infection
IBCLC - International Board-Certified Breastfeeding Consultants
IHA – Initial Health Appointment
LEP – Limited English Proficiency
PNA – Population Needs Assessment
WIC – Women, Infants and Children, federal nutrition program

AFFECTED DEPARTMENTS/PARTIES

Communications and Outreach
Member Services
Provider Services
Case and Disease Management

RELATED POLICIES AND PROCEDURES

HED-002 Health Education Materials
HED-009 Diabetes Prevention Program
~~HCSP-001 Community Health Workers~~CHS-001 Community Health Worker Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Baby Steps Standard Work
HED Diabetes Prevention Program Standard Work
HED Hospital ED Asthma Referral Standard Work
HED Lactation Support Standard Work
HED Materials Standard Work
HED Member Request Standard Work
HED Programs Monitoring and Evaluation Standard Work

REVISION APPROVAL HISTORY

11/21/2006, 1/1/2008, 12/2009, 2/26/2010, 1/24/2013, 3/26/2014, 3/31/2015, 6/16/2016, 5/25/2017, 5/3/2018, 9/6/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, **12/19/2023**, 03/19/2024, 4/16/2025, **11/19/2025**, **TBD**

Blue = material updates

REFERENCES

All Plan Letter 18-018 Diabetes Prevention Program
DHCS Contract, Exhibit A, Attachment 9, 10
MMCD Policy Letter 02-04 Health Education
MMCD Policy Letter 98-10 Breastfeeding Promotion
W&I Code section 144.07.1
Title 22, CCR, Sec. 53853 (c)
CMS Managed Care Manual

MONITORING

The Alliance annually reviews the health education policies and procedures to ensure compliance with contracts and policy letters and accepted guidelines and standards.

POLICY AND PROCEDURE

Policy Number	HED-002
Policy Name	Health Education Materials
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	11/21/2006
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

This policy concerns written health education materials that members receive from Alameda Alliance for Health and Alameda Alliance Wellness D-SNP (the Alliance). It applies to all members in all lines of business. The Alliance has a process for development and review of health education materials for members. The Alliance assures that materials meet required readability, suitability, accessibility, and content accuracy standards necessary to promote clear communication and understanding of health plan benefits, wellness, and disease self-management information for our diverse membership.

PROCEDURE

1. The Health Education Department uses the guide *Document A. Definitions and Requirements*, to determine which written documents are considered health education or member information materials. All Alliance collateral is reviewed by the Communications and Outreach Department. The Compliance Department reviews and submits member information documents to the Department of Health Care Services (DHCS) for approval prior to use.

2. Health education materials will be approved by a qualified health educator employed by the Alliance. The qualified health educator reviews all health education materials (plan-generated, adapted, purchased, or obtained free-of-charge) using the DHCS Readability and Suitability Checklist for Written Health Education Materials.
   2.1. Newly acquired materials will be reviewed when they are procured and before distributed to members, providers, and staff.
   2.2. Materials can be reviewed for readability standards and approved without completing the Readability and Suitability Checklist if they were produced by the following sources and no significant changes were made:

2.2.1. State-approved companies listed in 'Approved Companies for Written Health Education Materials' letter,
2.2.2. City, county, state, and federal government agencies, and
2.2.3. Non-profit agencies or community-based organizations when there is documentation on file that shows the material meets readability and suitability guidelines.

2.3. Materials are reviewed at least every five years or any time there are changes to health guidelines that affect the accuracy of the content.
2.4. Materials are updated as needed. Review may occur when there is a change in best practices or a regulatory board (i.e., DMHC, DHCS or CMS) mandates a change in health practices.
2.5. The Alliance maintains a signed and approved Readability and Suitability Checklist, including justification if needed, with the material and makes it available upon request to DHCS and other auditing agencies.

3. The Alliance uses the Simple Measure of Gobbledygook (SMOG) Readability Formula, the Flesh-Kinkaid readability tool, or a comparable language assessment tool for readability analysis.
   3.1. The formula is applied to the English version of all health education materials.
   3.2. Materials meet a readability score of sixth grade reading level or less and are at least 12-point font.
   3.3. A copy of the readability score calculation is kept with the completed Readability and Suitability Checklist.
   3.4. The evaluation of readability and suitability may exclude State-mandated legal language and MCP or vendor legal disclaimers; proper nouns; defined words; phone numbers; and website addresses. Medical terminology, technical words and/or multi-syllable words that must be included in health education material and cannot be substituted for simpler words are counted once.

4. As a part of the Readability and Suitability Checklist, the qualified health educator evaluates health education materials for other readability factors such as content accuracy, use of plain language and key messages, literacy level, layout, visuals, and cultural appropriateness.

The Alliance's Population Health & Equity Director maintains oversight for the field testing of all health education materials and documents the results on the Readability and Suitability Checklist.

4.1. Field-testing is optional for the following:
4.1.1. Brief updates on preventing colds and availability of seasonal flu vaccine
4.1.2. Newsletters
4.1.3. Materials developed by local county/city health departments, California state governmental organizations or the US federal government

4.1.4. Materials developed by a non-profit agency or community-based organization
4.1.5. Materials field-tested by a vendor when the qualified health educator has determined that the field-testing was conducted appropriately and with participants that represent a population similar to the targeted Alliance members
4.1.6. Materials that are from the DHCS list of approved vendors
4.1.7. Materials field-tested by another Medi-Cal Managed Care Plan
4.1.8. Material similar to another that was previously field-tested

4.2. When field-testing is not done because it is not required, the reason is documented on the Readability and Suitability Checklist.

4.3. The field-testing may include:
4.3.1. Review by the Community Advisory Committee
4.3.2. Key informant interviews with members, community informants, or internally qualified reviewers
4.3.3. Focus groups with targeted members
4.3.4. Written member or community informant surveys

5. Member health education materials containing clinical information are reviewed by the most appropriate clinical staff.
5.1. Medical accuracy is verified by the plan's nursing/pharmacy staff and/or Medical Directors. Clinical staff signs an attestation once clinical accuracy is confirmed. Attestations documented via email are acceptable.
5.2. Accuracy of content related to plan procedures, policies and applicable regulations is reviewed by plan staff whose responsibilities focus on the subject matter.

6. Health education materials may be approved by the health educator without meeting all factors on the Readability and Suitability Checklist if in the best judgment of the Health Educator, the document is appropriate for members, and the written rationale is included with the Readability and Suitability Checklist.

7. Members, family members or providers can request plan-produced educational materials in alternative formats, including Braille, accessible PDFs, large print, CD, audio, or online access by calling the Member Services Department or making a request online through the Alliance Member Portal. Alliance staff then contacts the Communications and Outreach Department who fills the request within 21 business days.
7.1. Vendor-produced materials are provided in alternate formats whenever possible, or materials of similar content are provided in alternate formats. When required, the Readability and Suitability Checklist is used to assess and approve written health education materials before conversion to an alternative format.
7.2. Members can make a standing request for an alternate format for member communications.

7.3. If providing an alternative format causes undue hardship, the Alliance will provide the information in another reasonable format, such as by phone or in-person from the plan health educator or other qualified staff (i.e., Nurse Case Manager).

8. Plan-generated informing documents and health education materials are translated into threshold languages. Upon member request, any Alliance department can request translation of member documents into non-threshold languages by submitting a request to the Communications and Outreach Department. Documents are translated according to Policy and Procedures *C&O-001 Community Relations and Outreach Activities* and *CLS-003 Language Assistance Services*.

9. The Health Education department will train and advise any Alliance department as needed regarding the readability and suitability of member documents and requirements regarding literacy level, plain language, translation, and alternative format for vision and hearing-impaired options or other disability accommodations.

10. Health education information that can be downloaded for use by members on the Alliance website is assessed and approved using the Readability and Suitability Checklist and field-tested if required. Alliance Health Education website text and linked external websites are regularly reviewed for readability and cultural appropriateness.

11. Alliance newsletters principally contain health education messages that are developed using readability and suitability guidelines.

DEFINITIONS/ACRONYMS

CMS – Centers for Medicare & Medicaid Services
DHCS – Department of Health Care Services
DMHC – California Department of Managed Health Care
Field-testing - A process through which member materials are reviewed by the target audience either through in-person review, key informant interviews, focus groups or surveys.
Health education materials – Designed to help members modify personal health behaviors, achieve, and maintain healthy lifestyles, and promote positive health outcomes by including information on health conditions, self-care, and management of health conditions. Topics may include messages about preventive care, health promotion, screenings, disease management, and healthy living.
MCP – Managed Care Plan
Member information materials – Provide members with essential information about access to and usage of Plan services. Evidence of Coverage, booklets, enrollment and disenrollment information, member rights and grievance information, new member

welcome packets, provider directories, flyers promoting a health education class, and appointment reminders are examples of informing materials.

Plain language - Plain language is clear and concise and uses short sentences and simple words. It keeps to the facts and is easy to read and to understand. Plain language is so clear, the reader can take in the writer's exact message in one reading.

Qualified health educator – A qualified health educator must have one of the following qualifications:

- Master of Public Health (MPH) degree with a specialization in health education or health promotion, from a program of study accredited by the Council on Education for Public Health, sanctioned by the American Public Health Association.
- MCHES (Master Certified Health Education Specialist) awarded by the National Commission for Health Education Credentialing, Inc.
- Training and background that is equivalent to the DHCS requirements for Health Education Consultants II/III.

SMOG - Simple Measure of Gobbledygook Readability Formula

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CLS-003 Nondiscrimination Language Assistance Services and Effective Communication for Individuals with Disabilities
C&O-001Community Relations and Outreach Activities
HED-001 Health Education Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Materials Standard Work

REVISION APPROVAL HISTORY

11/21/06, 1/1/2008, 12/2009, 2/26/2010, 3/28/11, 9/30/11, 3/25/2014, 5/20/2015, 6/16/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3192020, 3/18/2021, 3/17/2022, 3/21/2023, 03/19/2024, 4/16/2025, **11/19/2025, TBD**
Blue = material updates

REFERENCES

CA Health and Safety Code section 1367.04(b)
DHCS Contract, Exhibit A, Attachment 9, 10, 13
DHCS All Plan Letter 18-016 Readability and Suitability of Written Health Education
DHCS APL 18-016 Materials and Attachments:

- Document A. Definitions and Requirements
- Document B. Readability

- Suitability Checklist for Written Health Education Materials)
- DHCS Approved Companies for Written Health Education Materials

MONITORING

This policy will be reviewed annually to ensure effectiveness.

POLICY AND PROCEDURE

Policy Number	HED-006
Policy Name	Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL & D-SNP
Effective Date	6/16/2016
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Health and Alameda Alliance Wellness, D-SNP(the Alliance) provides Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services to members 11 years of age and older, including pregnant members who screen positively for potential alcohol misuse. This service was formerly named "Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care."

The Alliance is contractually required to provide all preventive services for members who are 21 years of age or older consistent with USPSTF Grade A and B recommendations. This policy aligns with the November 2018 and June 2020 updates to the United States Preventive Services Task Force (USPSTF) recommendations, AAP/Bright Futures and the Medi-Cal Provider Manual. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

This policy details the coverage of SABIRT services for the Alliance's Medi-Cal and D-SNP members and the procedures for SABIRT services. SABIRT services are provided by the member's primary care provider (PCP) to identify, reduce, and prevent problematic substance use. The Alliance does not require prior authorization for SABIRT services and referral to substance use disorder (SUD) evaluation or treatment. See *BH-005 Care Coordination – Behavioral Health* for details.

PROCEDURE

1. **General requirements:**
   1.1. Alliance providers must provide SABIRT services for members 11 years of age and older, including pregnant women. The services may be provided by providers within their scope of practice, including but not limited to the following:
      1.1.1. Licensed Physician
      1.1.2. Physician Assistant
      1.1.3. Nurse Practitioner
      1.1.4. Certified Nurse or Licensed Midwives
      1.1.5. Licensed clinical social workers
      1.1.6. Licensed professional clinical counselors
      1.1.7. Psychologists
      1.1.8. Licensed Marriage and Family Therapists.
   1.2. When providing SABIRT services, Alliance Providers must comply with all applicable laws and regulations regarding the privacy of substance use disorder (SUD) records, as well as state law concerning the right of minor over 12 years of age to consent to treatment (Title 42 CFR 2.1; 2.14; Family Code Section 6929).
   1.3. If a provider is unable to provide SABIRT, the PCP refers the Member to a provider who can provide SABIRT services. The referral and subsequent treatment do not require prior authorization.

2. **Screening Services**
   2.1 Unhealthy alcohol and drug use screening must be conducted using validated screening tools, including but are not limited to:
      2.1.1. Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
      2.1.2. Tobacco Alcohol, Prescription medication and other Substances (TAPS)
      2.1.3. National Institute on Drug Abuse (NIDA) Quick Screen for adults
      2.1.4. The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening
      2.1.5. Drug Abuse Screening Test (DAST-10)
      2.1.6. Alcohol Use Disorders Identification Test (AUDIT-C)
      2.1.7. Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
      2.1.8. Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
      2.1.9. Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

3. **Brief Assessment**
   3.1. When the screening is positive, Alliance providers use validated assessment tools to determine if unhealthy alcohol use or SUD is present. Validated assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

      3.1.1. NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
      3.1.2. Drug Abuse Screening Test (DAST-20)
      3.1.3. Alcohol Use Disorders Identification Test (AUDIT)

4. Brief Interventions and Referral to Treatment

4.1. For patients with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Brief interventions will include the following:

4.1.1. Providing feedback to the patient regarding screening and assessment results;

4.1.2. Discussing negative consequences that have occurred and the overall severity of the problem;

4.1.3. Supporting the patient in making behavioral changes; and

4.1.4. Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

4.2. If brief assessment demonstrates probable AUD or SUD, providers will offer appropriate referrals to Alameda County Behavioral Health (ACBH) or outpatient heroin detoxification providers available through Medi-Cal fee-for-service program for additional evaluation and treatment, including medications for addiction treatment.

4.2.1. Providers refer directly to ACBH or to the Alliance Behavioral Health Department for screening and referral to AUD or SUD treatment services.

4.2.2. Alliance case management team may also offer appropriate referrals to members for AUD or SUD treatment services.

4.2.3. SUD referrals and subsequent treatment do not require prior authorization.

4.3. The Alliance assists members in locating available treatment services sites, including pursuit of placement outside the area if no slots are available in county. If a medically necessary appointment is unavailable in a timely fashion, the Alliance Utilization Department will approve out-of-network services.

4.4. The Alliance covers and ensures the provision of primary care and other services unrelated to alcohol and SUD treatment and coordinates services between Primary Care Providers and treatment programs. Alliance providers are informed in the Provider Manual of their responsibility for appropriate care coordination, including care coordination for behavioral health care.

4.5. Providers will make good faith efforts to confirm whether members receive referred treatment and document when, where, and any next steps following treatment. If no treatment was received, providers will follow up with the member to understand barriers and make any needed changes to the referrals. When needed, the provider will facilitate a warm hand off to treatment.

5. Documentation Requirements

5.1. Member medical records must include the following:

5.1.1. The service provided (e.g., screen and brief intervention);

5.1.2. The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);

5.1.3. The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and

5.1.4. If and where a referral to an AUD or SUD program was made.

5.2. The Alliance Quality Improvement Department will ensure provider compliance with SABIRT requirements through the Medical Record Review process (see QI-105

Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)).

5.3. When members transfer from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services.

5.4. The Alliance will inform members of SABIRT services through the Alliance Member Handbook.

DEFINITIONS / ACRONYMS

4Ps - Parents, Partner, Past and Present for pregnant women and adolescents
ACBH – Alameda County Behavioral Health
AUD – Alcohol Use Disorder is the recurring use of alcohol to the point that it interferes with the user's responsibilities and/or physical health.
AUDIT - Alcohol Use Disorders Identification Test
CAGE-AID - Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs
CRAFFT - Car, Relax, Alone, Forget, Friends, Trouble for non-pregnant adolescents
DAST – Drug Abuse Screening Test
FSR – Facility Site Review
MAST-G - Michigan Alcoholism Screening Test Geriatric
MRR – Medical Record Review
NIDA - National Institute on Drug Abuse
NM-ASSIST - NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test
PARS – Physical Accessibility Review Surveys
PCP – Primary Care Provider
SABIRT – Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
SUD – Substance Use Disorder is the recurring use of a substance (legal or illegal) to the point that it interferes with the user's responsibilities and/or physical health.
TAPS - Tobacco Alcohol, Prescription medication and other Substances
Unhealthy Alcohol Use - A spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence)
Unhealthy Drug Use - The use of illegally obtained substances, excluding alcohol and tobacco products, or the nonmedical use of prescription psychoactive medications.
USPSTF – United States Preventive Services Task Force

AFFECTED DEPARTMENTS/PARTIES

Claims/Operations
Compliance
Health Care Services
Provider Services

RELATED POLICIES AND PROCEDURES

QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

6/16/2016, 5/25/2017, 1/04/2018, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, **6/28/2022**, 3/21/2023, 03/19/2024, 4/16/2025, **11/19/2025**, **TBD**

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REFERENCES

DHCS All Plan Letter 21-014 - Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment
Family Code - Section 6929
Title 42 Code of Federal Regulations - Section 2.1 et seq., 2.14
USPSTF – November 2018 and June 2020 updates re: alcohol and drug use

MONITORING

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

POLICY AND PROCEDURE

Policy Number	HED-007
Policy Name	Tobacco Cessation
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL & D-SNP
Effective Date	6/16/2016
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Health and Alameda Alliance for Wellness, D-SNP (the Alliance) recognizes the role of Comprehensive Tobacco Cessation Services in disease prevention and the health of its membership. Therefore, the Alliance provides tobacco cessation services, coverage of cessation medications, counseling, anticipatory guidance, provider training and monitoring activities to support its members in their tobacco cessation efforts.

PROCEDURE

The Alliance implements and covers payment for the following tobacco cessation services:

1. The Alliance requires its providers to conduct initial and annual assessments of tobacco use for each adolescent and adult member to identify all members (of any age) who use tobacco products and note use in the member's medical record. The Alliance requires providers to document the following to track all tobacco use.
   1.1. Providers must complete the Individual Health Appointment (IHA) which includes review of the social history of the member which includes tobacco use (See Alliance policy and procedure *QI-124 IHA*).
   1.2. Providers must annually assess tobacco use status for every member.
   1.3. Providers must ask tobacco users about their current tobacco use at every visit.
   1.4. Provider Services informs primary care providers of the requirements regarding assessment of tobacco use during the New Provider Orientation and yearly thereafter in provider office visits.

1.5. Tobacco user identification will be reviewed during their routine facility site review to confirm compliance. (Reference: QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS).

2. Medi-Cal and D-SNP ~~will~~ provide coverage of prescription smoking/tobacco cessation covered outpatient drugs. However, ~~and while~~ only Medi-Cal covers Over-The-Counter (OTC) smoking/tobacco cessation covered outpatient drugs as recommended in "Treating Tobacco Use and Dependence: 2008 Update" published by the U.S. Public Health Service in May 2008 or any subsequent modification of such guideline.
   2.1. Although the Patient Protection and Affordable Care Act (ACA) Section 4107 authorizes coverage of counseling and pharmacotherapy for tobacco cessation for pregnant persons, the U.S. Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant persons. Providers refer to the tobacco cessation guidelines by the American College of Obstetricians and Gynecologists (ACOG) before prescribing tobacco cessation medications during pregnancy.

3. Prescription and OTC smoking/tobacco cessation products are covered via the Medi-Cal Rx Contract Drugs List (CDL), https://medi-calrx.dhcs.ca.gov/home/cdl/.
   3.1. Quantity limits and other restrictions for the medications are also available in the CDL.
   3.2. Providers will need to ensure they can submit prior authorization (PAs) for any drug that will require authorization from Medi-Cal Rx. Here are the different ways that providers can register or submit a PA:
      3.2.1. **Medi-Cal Rx Secure Portal:** The prior authorization (PA) system information and forms are available on the Medi-Cal Rx website at **www.medi-calrx.dhcs.ca.gov**. Providers can check the status of requests on Medi-Cal Rx Provider Portal or by phone by calling the Medi-Cal Rx Call Center Line toll-free at **1.800.977.2273**. Please refer to **www.medi-calrx.dhcs.ca.gov**.
      3.2.2. **CoverMyMeds:** Providers can create an account and log in to submit a PA on the CoverMyMeds website at **www.covermymeds.com**. If you currently use CoverMyMeds, you can continue to utilize this platform to submit a PA. A link to CoverMyMeds can also be found in the Medi-Cal Rx Secure Portal. ***Please prioritize this submission process to minimize delays.**
      3.2.3. **NCPDP P4:** To view the Prior Authorization Request Only (P4) Payer Sheet Template, please visit **medi-calrx.dhcs.ca.gov/provider/forms**.
      3.2.4. **By Fax**: PA requests and attachments can be faxed to **1.800.869.4325**.
      3.2.5. **By mail:** PA requests and attachments can be mailed to: Medi-Cal Rx Customer Service Center; Attn: PA Request; P.O. Box 730; Sacramento, CA 95741-0730.

3.3. The Alliance covers reimbursement for pharmacist professional services for furnishing nicotine replacement as required by Welfare and Institutions Code Section 14132.968 (W&I 14132.968) in a community-based outpatient pharmacy setting.

3.4. The Alliance covers processing and payment of all pharmacists' professional services for furnishing nicotine replacement as allowed by W&I 14132.968that are billed on medical and institutional claims.

~~3.4.~~3.5. D-SNP tobacco cessation drug coverage may be found by searching the D-SNP formulary found on the Alliance Wellness webpage.

4. The Alliance provides individual, group, and telephone counseling for members of any age who use tobacco products and who wish to quit smoking.
   4.1. Providers receive codes they can use for reimbursement in their New Provider Orientation and regularly thereafter. The Alliance covers four counseling sessions of at least 10 minutes in duration and covered at least two separate quit attempts per year without prior authorization.
   4.2. The Alliance encourages providers to use the "5 A's" model (see https://www.ahrq.gov/prevention/guidelines/tobacco/5steps.html) or other validated behavior change models when counseling patients.
   4.3. The Alliance ensures that providers refer members to Kick It California (https://www.kickitca.org/) or the Asian Smokers' Quitline (https://www.asiansmokersquitline.org/).
   4.4. Providers may refer members or members can self-refer to Alliance sponsored tobacco cessation group classes or telephone counseling through Kick It California or the Asian Smokers' Quitline.
      4.4.1. The Alliance maintains a list of available tobacco cessation services and collaborates with the local county tobacco control program.
      4.4.2. Members and providers connect with the programs through the Alliance Wellness Request Form, by calling Alliance Health Programs, or through referral from their provider or Alliance Case Management staff.
      4.4.3. The Alliance refers members directly to Kick It California.
   4.5. All individual, group and telephone counseling options are free to Alliance members.

5. The Alliance provides services for pregnant tobacco users. At a minimum, providers:
   5.1. Ask all pregnant persons if they use tobacco or are exposed to tobacco smoke and advise them to stop using tobacco.
   5.2. Offer all pregnant smokers during pregnancy at least one face-to-face counseling session per quit attempt. The counseling services will be covered for 60 days after delivery plus any additional days up to the end of the month.
   5.3. Refer pregnant persons to a tobacco cessation quit line.
   5.4. Refer to the American College of Obstetrics and Gynecology (ACOG) Guidelines before considering offering tobacco cessation medication during pregnancy.

6. The Alliance PCPs provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

6.1. The Alliance covers medically necessary tobacco cessation services, both counseling and medications for children up to age 21 in compliance with Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.
6.2. Services will be provided in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance, as periodically updated.

7. The Alliance informs and educates clinicians on to effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant persons and where to find on-line courses.
   7.1. The Provider Services Department conducts provider training on tobacco cessation services. (Reference: PR-001 – New Provider Orientation)
   7.2. As required in our Department of Health Care Services (DHCS) contracts, provider training includes:
      7.2.1. Any new requirements for comprehensive tobacco cessation member services including Policy Letter 16-014, or superseding APL or Contract Amendment;
      7.2.2. The overview of the "Treating Tobacco Use and Dependence: 2008 Update;"
      7.2.3. How to use and adopt the "5 A's" for treating tobacco use and dependence in the provider's clinic practice;
      7.2.4. Requirements for pregnant tobacco users;
      7.2.5. Requirements regarding preventing tobacco use in children and adolescents, and
      7.2.6. Available online courses in tobacco cessation.
   7.3. Provider training links are available on the AAH website. Tobacco related training opportunities are shared with providers as available.

8. The Alliance will ensure that our primary care practices institute a tobacco user identification system per USPSTF recommendations. Reports on tobacco use are used to coordinate members' tobacco cessation interventions.
   8.1. The Alliance annually reviews a report on Alliance tobacco users that combines Nicotine Replacement Therapy (NRT) claims, health risk assessment results, case management data and ICD-10 codes for nicotine dependence.
   8.2. Summary reports are reviewed annually at the Internal Quality Improvement Committee..

9. Tracking Treatment Utilization of Tobacco Users
   9.1. The Alliance maintains a system to track utilization of tobacco cessation interventions. Utilization is tracked through NRT pharmacy claims, aggregate reports from Kick It California, Alliance smoking cessation class referrals, and CAHPS survey results.
   9.2. Summary reports are reported at least annually at the Alameda Alliance for Health's (AAH) Internal Quality Improvement Committee..

10. The tobacco use and treatment utilization results are used to guide plan and provider screening and cessation interventions and track prevalence over time.

DEFINITIONS / ACRONYMS

5 A's – Ask, Advise, Assess, Assist, and Arrange
AAH – Alameda Alliance for Health
ACA – Affordable Care Act
ACOG - American College of Obstetricians and Gynecologists
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CDL – Medi-Cal Rx Contracted Drugs List
DHCS – Department of Health Care Services
EPSDT - Early and Periodic Screening, Diagnosis and Treatment
FDA – Federal Drug Administration
FSR – Facility Site Review
ICD-10 – International Classification of Diseases, Tenth revision
IHEBA – Individual Health Education and Behavioral Assessment
MRR – Medical Record Review
NRT – Nicotine Replacement Therapy
OTC – Over-The-Counter
PA – Prior Authorization
PARS – Physical Accessibility Review Surveys
PCP – Primary Care Physician
USPHS – United State Public Health Service
USPSTF – United States Preventive Services Task Force

AFFECTED DEPARTMENTS/PARTIES

Compliance
Pharmacy
Provider Services
Quality Improvement
Utilization Management

RELATED POLICIES AND PROCEDURES

UM-018 Targeted Case Management (TCM) and EPSDT Supplemental
PR-001 New Provider Orientation
QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS)
QI-124 Individual Health Appointment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Tobacco Strategy Standard Work

REVISION APPROVAL HISTORY

6/16/2016, 5/25/2017, 1/4/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, 03/19/2024, 4/16/2025, **11/19/2025,** **TBD**

Blue = material updates

REFERENCES

- American College of Obstetrics and Gynecology, Tobacco Cessation Guidelines
- Department of Health Care Services (DHCS) All Plan Letter 16-014 Tobacco Cessation
- DHCS All Plan Letter 22-012 Governor's Executive Order N-01-19, regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
- DMHC APL 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx
- Medi-Cal Rx Provider Manual
- U.S. Public Health Service, Treating Tobacco Use and Dependence: 2008 Update
- Welfare and Institutions Code Section 14132.968 (Assembly Bill (AB) 1114 (Chapter 602, Statutes of 2016))

MONITORING

The Quality Improvement Department will review the policy annually for compliance with regulatory and contractual requirements.

POLICY AND PROCEDURE

Policy Number	HED-009
Policy Name	Diabetes Prevention Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, D-SNP
Effective Date	5/16/2019
Administrative Oversight Committee Meeting	~~11/19/2025~~TBD

POLICY STATEMENT

In accordance with APL 18-018 Alameda Alliance for Health (The Alliance) and Alameda Alliance for Wellness, D-SNP, covers the Diabetes Prevention Program (DPP) and the Medicare Diabetes Prevention Program (MDPP) benefit to eligible members. ~~-~~DPP/MDPP programs are a part of the Alliance' Basic Population Health Management strategies. Members at risk for diabetes who participate in DPP/MDPP programs learn to make healthy lifestyle choices that reduce their risk of diabetes.

PROCEDURE

1. The Alliance contracts with DPP provider(s) who deliver direct services to members through sessions taught by peer coaches. The Alliance ensures that the DPP providers comply with the most current Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) guidelines and obtain pending, preliminary, or full CDC recognition. The Alliance also follows the most current guidelines from CMS Centers for Medicare and Medicaid Services, the Medicare Diabetes Prevention Program (MDPP). As well as the National Committee for Quality Assurance Standards (NCQA).

   Our contracted DPP/MDPP providers use a CDC-approved lifestyle change curriculum that does all of the following:

   1.1. Emphasizes self-monitoring, self-efficacy, and problem solving,
   1.2. Provides for coach feedback,
   1.3. Includes participant materials to support program goals, and
   1.4. Requires participant weigh-ins to track and achieve program goals.

   ~~1.4.~~1.5. The Alliance contracts with MDPP providers that comply with the requirements defined in CFR Title 42 § 410.79.

2. DPP/MDPP sessions are taught by peer coaches, also known as lifestyle coaches, who promote realistic lifestyle changes, emphasize weight loss through healthy eating and physical activity, and implement the DPP/MDPP curriculum.

3. Benefit eligibility period:
   ~~3.1.~~ Members must meet the most current CDC DPRP participant eligibility requirements to qualify for the DPP benefit.
   3.1.
   3.2. A D-SNP member is eligible for MDPP services offered during the core services period as defined in CFR Title 42 § 410.79.

4. The Alliance covers a minimum of 22 DPP/MDPP sessions for the first 12 months of the DPP benefit. Months one (1) through 12, known as the core services period, consist of weekly core sessions in the first six (6) months followed by monthly core maintenance sessions in the next six (6) months. Thereafter, the Alliance will provide 12 months of ongoing maintenance sessions to qualified members to promote continuous healthy behaviors.
   4.1. A member will qualify for the ongoing maintenance sessions if:
      4.1.1. The member achieves and/or maintains minimum weight loss of five percent for the first core session, and
      4.1.2. The member meets the attendance requirement, as outlined in the Medi-Cal Provider Manual.
   4.2. The Alliance accepts the below modalities for the required weigh-ins:
      4.2.1. In-person weigh-in at a DPP session or DPP provider location;
      4.2.2. A remote weigh-in at the member's home using scales with digital or Bluetooth communications capability; or
      4.2.3. Self-reported weigh-ins with or without confirmatory documentation.
   ~~4.2.3.~~4.3. The Alliance administers the MDPP program in compliance with the conditions of coverage, beneficiary eligibility, services period, limitations and any subsequent rulemaking as defined in CFR Title 42 § 410.79.

5. The Alliance may cover the following delivery methods:
   5.1. For DPP sessions as deemed clinically appropriate:
      5.1.1. In-Person,
      5.1.2. Distance Learning,
      5.1.3. Online, or
      5.1.4. Combination – Combination refers to any combination of in-person, distance learning, or online delivery methods.
   5.2. For MDPP sessions:
      5.2.1. In-person~~, or~~
      5.2.2. Distance learning (live virtual), or
      ~~5.2.2.~~5.2.3. CMS-approved online asynchronous modality (when applicable)

6. Duration of the benefit:
   6.1. The DPP benefit will be offered as often as necessary, but the member's medical record must indicate that the member's medical condition or circumstance warrants repeat or additional participation in the DPP benefit. The Alliance will use the below

circumstances when identifying members who warrant repeat or additional participation:

6.1.1. Member switched enrollment from one MCP to a different MCP,
6.1.2. Member transitioned from Fee-for-Service Medi-Cal into an MCP,
6.1.3. Member moved to a different county,
6.1.4. Member experienced a lapse in Medi-Cal enrollment, and
6.1.5. Member has, or had, medical conditions that hinder DPP session attendance.

6.2. The MDPP benefit may last up to one year and include 22 sessions. Ongoing Maintenance (months 13–24) are tied to attendance and weight-loss milestones. The full set of MDPP services is available only once per lifetime for each MDPP beneficiary.

7. The Alliance will ensure that DPP/MDPP providers use a CDC-approved curriculum. DPP/MDPP providers may use either the official CDC curriculum or a modified curriculum that has been approved by the CDC. MDPP providers must be enrolled in Medicare as an MDPP supplier.

8. The Alliance will ensure that DPP and MDPP services are provided in a culturally and linguistically appropriate manner. All translated curriculum materials will be made available to members timely and meet all applicable requirements.

9. The Alliance will maintain documentation of appropriate codes for all DPP/MDPP services.

DEFINITIONS / ACRONYMS

CDC – Centers for Disease Control and Prevention
CMS – Center for Medicare and Medicaid Services
DPP - Diabetes Prevention Program - an evidence-based lifestyle change program, taught by peer coaches, designed to prevent, or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes.
MDPP – Medicare Diabetes Prevention Program
DPRP - Diabetes Prevention Recognition Program
Peer Coach - a physician, non-physician practitioner, or an unlicensed person who is trained to deliver the required curriculum content and who possesses the skills, knowledge, and qualities specified in the most current CDC DPRP guidelines.
In-Person Delivery - For in-person delivery, members are physically present in a classroom or classroom-like setting with a peer coach.
Distance Learning Delivery - Distance learning occurs when peer coaches deliver sessions via remote classroom or telehealth. The peer coach is present in one location while participants call in or participate by videoconference from another location.
Online Delivery - Online delivery can be conducted either through synchronous real-time interactive audio and video telehealth communication or through asynchronous store and forward telehealth communication. Members can log into DPP/MDPP sessions via a computer, laptop, tablet, mobile phone, or other device from any location, such as the member's home, without a practitioner or coach present. In addition, members must interact with peer coaches at various times and by various communication methods, including but not limited to online classes, emails, phone calls, or texts.

AFFECTED DEPARTMENTS/PARTIES

Member Services
Quality Improvement

RELATED POLICIES AND PROCEDURES

HED-001 Health Education Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

HED Diabetes Prevention Program (DPP) Standard Work

REVISION APPROVAL HISTORY

5/16/2019, 3/19/2020, 3/18/2021, 3/17/2022, 3/21/2023, 3/19/2024, 4/16/2025, **11/19/2025**, TBD

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REFERENCES

- CDC-approved curriculum
- CMS-Medicare Managed Care Manual IOM,100-16, Chapter 4, (30.3 Health Education)
- Code of Federal Regulations (CFR) Title 45, Part 92
- Code of Federal Regulations (CFR) Title 42, Part 410
- DHCS All Plan Letter (APL) 18-018 Diabetes Prevention Program or superseding APL
- Patient Protection and Affordable Care Act §1557 (42 United States Code (USC) §18116)
- WIC Section 14029.91

MONITORING

The Alliance will ensure compliance of providing the DPP/MDPP benefit through monitoring of our contracted DPP/MDPP providers. Monitoring will include tracking and trending of grievances and appeals that are filed against our contracted provider(s).

POLICY AND PROCEDURE

Policy Number	HED-010
Policy Name	Doula Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal, IHSS, D-SNP
Effective Date	12/19/2023
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

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

PROCEDURE

1. Recommendations for Doula Services

1.1. Alliance Doula Services require a written recommendation by a physician or other Licensed Practitioner of the healing arts within their scope of practice under state law.
- 1.1.1. The recommending practitioner ***does not*** need to be enrolled in Medi-Cal or be a Network Provider with the Plan.
- 1.1.2. The written recommendation should be kept in the member records maintained by doulas.

1.2. Recommendation for doula services includes the following authorizations:
- 1.2.1. One initial visit.
- 1.2.2. Up to eight additional visits that can be provided in any combination of prenatal and postpartum visits.
- 1.2.3. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage.
- 1.2.4. Up to two extended three-hour postpartum visits after the end of a pregnancy

1.3. The initial recommendation can be provided through the following methods:
- 1.3.1. Written recommendation in Member's record.

1.3.2. Standing recommendation for doula services by a physician group, or other group by a licensed Provider.
1.3.2.1. The standing recommendation issued by DHCS on November 1, 2023, fulfills this requirement until the time it is rescinded or modified.
1.3.3. Standard form signed by a physician or other licensed practitioner that a member can provide to the doula, such as the DHCS Medi-Cal Doula Services Recommendation form.
1.3.4. The Alliance may develop a recommendation form that best meets the needs for the Alliance and Alliance providers.
1.4. Additional visits:
1.4.1. A second recommendation is required for additional visits during the postpartum period.
1.4.2. A recommendation for additional visits during the postpartum period **CANNOT** be established by standing order.
1.4.3. The additional recommendation authorizes nine or fewer additional postpartum visits.

2. Role of Doula

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

3. Doula Qualifications

3.1. All doulas must (a) be at least 18 years old, (b) provide proof of an adult and infant Cardiopulmonary Resuscitation (i.e., CPR) certification from the American Red Cross or American Heart Association, and (c) they attest they have completed basic Health Insurance Portability and Accountability Act training.
3.2. Doulas must obtain training for their services through their choice of two pathways:
3.2.1. Training Pathway:
3.2.1.1. Certificate of completion for a minimum of 16 hours of training which includes the following topics:
3.2.1.1.1. Lactation support
3.2.1.1.2. Childbirth education
3.2.1.1.3. Foundations on anatomy of pregnancy and childbirth
3.2.1.1.4. Nonmedical comfort measures, prenatal support, and labor support techniques
3.2.1.1.5. Developing a community resource list
3.2.1.2. Attest that they have provided support at a minimum of three births
3.2.2. Experience Pathway: ***All requirements*** listed below need to be met for this option:
3.2.2.1. Attest that they have provided services in the capacity of a doula

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

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

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

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

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

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

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

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

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

4. Member Eligibility and Access

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

4.1.1. They are currently enrolled as an Alliance member.

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

4.1.1.2. Doulas must contact the Alliance to verify eligibility.

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

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

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

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

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

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

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

5. Service and Billing Parameters

5.1. The Alliance provides doula services for prenatal, perinatal, and postpartum members.
5.2. Doula visits are limited to one per day, per member.
5.3. Services can be provided virtually or in-person with various locations including, but not limited to homes, office visits, hospitals or alternative birth centers.
5.4. A doula can bill for a prenatal or postpartum visit on the day of labor/delivery, stillbirth, abortion, or miscarriage support.
5.5. Extended three-hour postpartum visits provided after the end of pregnancy do not require the member to meet additional criteria or receive a separate recommendation.
5.6. The extended visits are limited to two visits per pregnancy per individual on separate days and are billed in 15-minute increments, up to three hours.
5.7. Doulas will work with the Member's Primary Care Provider (if information is available) or with the Alliance for coordination of care for any services available through Medi-Cal by referring the member to an Alliance provider to render the service. These services include but not limited to:
  5.7.1. Behavioral health services
  5.7.2. Belly binding after cesarean section by clinical personnel
  5.7.3. Clinical case coordination
  5.7.4. Health care services related to pregnancy, birth, and the postpartum period
  5.7.5. Childbirth education group classes
  5.7.6. Comprehensive health education including orientation, assessment, and planning (Comprehensive Perinatal Services Program services)
  5.7.7. Hypnotherapy (non-specialty mental health service)
  5.7.8. Lactation consulting, group classes, and supplies
  5.7.9. Nutrition services (assessment, counseling, and development of care plan)
  5.7.10. Transportation
  5.7.11. Medically appropriate Community Supports services
5.8. **Gender Override:** Medi-Cal and D-SNP members of all gender identities may receive doula services so long as they are medically necessary and meet all other requirements for Medi-Cal and D-SNP coverage. Doulas should ensure that the appropriate billing code (CPT or HCPCS code) is listed on the claim in conjunction with an appropriate ICD-10 diagnosis code to ensure the claim does not deny
5.9. Doula services **DO NOT** include diagnosis of medical conditions, provision of medical advice or any type of clinical assessment, exam, or procedure. However, claims should include a diagnosis code provided by the referring provider.
5.10. Services that **ARE NOT** covered under Medi-Cal or as doula services include:
  5.10.1. Belly binding (traditional/ceremonial)
  5.10.2. Birthing ceremonies (sealing, closing the bones etc.)
  5.10.3. Group classes on babywearing
  5.10.4. Massage (maternal or infant)
  5.10.5. Photography
  5.10.6. Placenta encapsulation
  5.10.7. Shopping
  5.10.8. Vaginal steams

5.10.9. Yoga

5.11. Doulas **ARE NOT** prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit (i.e., a doula may help the postpartum person fold laundry while providing emotional support and offering advice on infant care).

5.11.1. The visit must be face-to-face, and the assistive or supportive service must be incidental to doula services provided during the prenatal or postpartum visit.

5.11.2. The Member cannot be billed for the assistive or supportive service.

5.12. Doulas ARE NOT prohibited from teaching classes available at no cost to Members to whom they provide doula services.

5.13. Doula Documentation:

5.13.1. Doulas must document the dates, time, and duration of services provided to Members.

5.13.2. Documentation must also reflect information on the service provided and the length of time spent with the Member that day. For example, documentation might state, "Discussed childbirth education with the Member and discussed and developed a birth plan for one hour."

5.13.3. Documentation should be integrated into the Member's medical record and available for encounter data reporting.

5.13.4. The doula's National Provider Identifier (NPI) number should be included in the documentation.

5.13.5. Documentation must be accessible to the Alliance and DHCS upon request.

6. Reimbursement for Doula Services

6.1. The Alliance Claims Department makes payments in compliance with the clean claims requirements and timeframes outlined in the DHCS MCP Contract and Timely Payments under DHCS All Plan Letters. These requirements apply to both the Alliance and our Network Providers and Subcontractors. (See Alliance Policy *CLM-010 Family Planning and Sensitive Services)*.

6.2. MCPs must reimburse doulas in accordance with their Network Provider contract.

6.3. If a member chooses to see an out-of-network provider for abortion services, the reimbursement rate will not be lower, nor is required to be higher, than the Medi-Cal Fee-For-Service rate, unless the out-of-network provider and the Alliance mutually agree to a different reimbursement rate.

6.4. The Alliance is prohibited from establishing unreasonable or arbitrary barriers for accessing doula services.

6.5. Claims for doula services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

6.6. Doulas **CANNOT** double bill, as applicable, for doula services duplicative to services reimbursed through other benefits.

7. Population Health Management

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

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

7.1.2. Priority populations are selected based on the unique needs of the Alliance membership, identified health disparities, and the DHCS Clinical Quality Strategy priorities.
7.1.3. The Alliance collaborates with community partners and providers to ensure priority populations connect to doula services.
7.1.4. The Alliance may also receive referrals from licensed practitioners for Doula benefits.

8. MCP Oversight

8.1. The Alliance must provide doulas with all necessary, initial, and ongoing training and resources regarding relevant Health Plan prenatal, perinatal, and postpartum services and processes, including any MCP services available to prenatal, perinatal, and postpartum members.
8.1.1. This training must be provided initially when doulas are enrolled with the MCPs, as well as on an ongoing basis.
8.2. The Alliance is required to provide technical support in the administration of doula services, ensuring accountability for all service requirements contained in the Contract, and any associated guidance issued by DHCS.
8.3. The Alliance ensures that Doula Services Providers have NPIs and that these NPIs are entered in the 274 Network Provider File.
8.4. The Alliance will ensure that all doulas complete three hours of continuing education in maternal, perinatal, and/or infant care every three years. Doulas must maintain evidence of completed training to be made available to DHCS upon request.
8.5. The Alliance must ensure doulas document the dates, time, and duration of services provided to Members.
8.6. The Alliance must ensure and monitor sufficient Provider Networks within their service areas, including doulas.
8.6.1. To support an adequate doula Network, the Alliance must make contracting available to both individual doulas and doula groups.
8.6.2. The Alliance works with Alliance network hospitals/birthing centers to help ensure there are no barriers to accessing doulas when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits regardless of outcome (stillbirth, abortion, miscarriage, live birth).
8.6.3. If an Alliance member desires to have a doula during labor and delivery, the Alliance will work with in-Network hospitals and birthing centers to allow the doula, in addition to the support person(s), to be present.
8.6.4. The Alliance coordinates out-of-Network access for doula services for members if an in-network doula provider is not available for medically necessary services. Out-of-Network care will be coordinated as defined by Alliance policy *UM-002 Coordination of Care*.
8.7. The Alliance will monitor utilization of services and requirements and comply with all reporting and oversight requirements stipulated by DHCS.
8.7.1. Utilization monitoring will include, at the minimum, an annual review of claims and encounters for Doula services and grievances and appeals related to Doula services.
8.7.2. Based on monitoring of Doula services, the Alliance will ensure sufficient provider networks for Doula services.

8.7.3. The Alliance is responsible for ensuring Alliance Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.

8.7.3.1. These requirements are communicated by the Alliance to all applicable Subcontractors and Network Providers.

DEFINITIONS / ACRONYMS

The Alliance: Alameda Alliance for Health
DHCS: Department of Health Care Services
Licensed Practitioner: For the purposes of the doula benefit, a licensed practitioner includes physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.
Doula: Birth workers who provide health education, advocacy, and physical, emotional and nonmedical support for pregnant and postpartum persons before, during and after childbirth (perinatal period) including support during miscarriage, stillbirth and abortion. Doulas are not licensed or clinical providers, and they do not require supervision.
Doula services: Doula services encompass health education, advocacy, and physical, emotional and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the postpartum period.
Evidence-based: A process whereby decisions are made, and actions or activities are understood using the best evidence available with the goal of removing subjective opinion, unfounded beliefs or bias from decisions and actions. Evidence can include practitioner experience and expertise as well as feedback from other practitioners and beneficiaries.
Full-spectrum doula care: Prenatal and postpartum doula care, presence during labor and delivery and doula support for miscarriage, stillbirth and abortion. Doula care includes physical, emotional and other non-medical care.
Postpartum period: Doulas may provide services for up to 12 months from the end of pregnancy. Beneficiaries are eligible to receive full-scope Medi-Cal coverage for at least 12 months after pregnancy.
MCP: Managed Care Plan
Network: Primary Care Providers (PCPs), Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom the Alliance enters into a Network Provider Agreement.
OON: Out-of-Network
Recommending Provider: The Licensed Practitioner who recommends a member for Doula services, and ensures the member meets medical necessity for Doula services.

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alliance Population Health Strategy

REVISION APPROVAL HISTORY

New Policy: 12/19/2023
Revised: **6/12/2024**, 5/21/2025, **11/19/2025**, TBD

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REFERENCES

APL 23-024 Doula Services or superseding All Plan Letters
APL 22-013 Interoperability and Patient Access Final Rule or superseding All Plan Letters
Title 42 of the Code of Federal Regulations, Section 440.130(c).

MONITORING

This policy will be reviewed annually to ensure effectiveness.

POLICY AND PROCEDURE

Policy Number	PH-001
Policy Name	Population Health Management (PHM) Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	9/19/2023
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) and Alameda Alliance for Wellness (D-SNP) maintains a Population Health Management (PHM) Program. The Alliance PHM Program aims to:

1. Ensure all members have equitable access to necessary wellness and prevention services, care coordination and care management.
2. Assess each member's needs across the continuum of care based on member preferences, data-driven risk stratification, identified gaps in care and standardized assessment processes.
3. Improve the health outcomes of all members.

The Alliance monitors its PHM Program to gain an internal understanding of the impact on quality and equity for groups serviced by the interventions.

The Alliance PHM Program meets all National Committee for Quality Assurance (NCQA) PHM standards as well as applicable federal and state requirements. The program complies with the California Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, the DHCS 2024 Managed Care Plan (MCP) Contract, or superseding DHCS policy guide and/or amended contract.

The Alliance PHM Program follows the DHCS Policy Guide Framework including the following four domains:

~~1. Population Health Management Strategy~~
~~2.~~1.~~Population Needs Assessment~~Local Planning and PHM Strategy
2. Gathering member information~~ and~~
3. ~~u~~Understanding risk
4. Providing supports and services

The Alliance follows the NCQA Health ~~Equity~~ Outcomes Accreditation standards for reducing disparities through regular stratification and analysis of key performance indicators.

PROCEDURE

1. The Alliance maintains full NCQA Health Plan Accreditation which includes the PHM standards.
   1.1. The Alliance ~~will obtain~~maintains NCQA Health ~~Equity~~ Outcomes Accreditation for Medi-Cal~~ by Jan 1, 2026~~.
2. The Alliance PHM Program includes the following components:
   2.1. PHM Strategy and ~~Population Needs Assessment (PNA)~~Local Planning
      2.1.1. The Alliance develops an annual NCQA population assessment and PHM Strategy in accordance with NCQA accreditation standards.~~-~~
      2.1.2. The Alliance fulfills ~~The~~the DHCS ~~PNA~~ Local Planning requirements ~~is met~~ through meaningful participation in Alameda County's and the City of Berkeley's Community Health Assessment/Community Health Improvement Plan (CHA/CHIP), which are conducted on a three-year cycle. Activities include collaboration, stakeholder engagement, data sharing, and resource contributions, as applicable, in accordance with DHCS PHM Policy Guide requirements.
      2.1.3. The Alliance also collaborates with county behavioral health departments on the CHA/CHIP and statewide population behavioral health goals.
      2.1.4. Findings from local planning activities, including identified community health priorities and statewide behavioral health goals, are incorporated into the Alliance's PHM Strategy and program planning processes.
      ~~2.1.2.~~2.1.5. The Alliance submits an annual ~~annual PNA and~~DHCS ~~-~~PHM Strategy D~~d~~eliverable ~~to DHCS in October~~in a form and manner specified by DHCS. (See *PH-005 Population Assessment*)

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   ~~2.3.~~2.2. Gathering member information through screenings and assessments
      ~~2.3.1.~~2.2.1. The Alliance conducts necessary screening and assessments to gain timely information on the health and social needs of all members, in accordance with applicable state and federal laws and regulations. The Alliance also ~~follows NCQA~~follows NCQA PHM standards. For implementation and monitoring details, see *QI-124 IHA Policy* and *CM-020 Health Information Form/Member Evaluation Tool (HIF/MET)*.
      ~~2.3.2.~~2.2.2. The Alliance contracts with providers to conduct assessments and integrate the results with care and care management processes.
      ~~2.3.3.~~2.2.3. The following populations are assessed:
         ~~2.3.3.1.~~2.2.3.1. Those with long-term services and supports (LTSS) needs (See *CM-008 SPD HRA - Survey and Interventions*)
         ~~2.3.3.2.~~2.2.3.2. Those entering Complex Case Management (CCM) (See *CM-001 CCM Identification Screening Enrollment and Assessment*)
         ~~2.3.3.3.~~2.2.3.3. Those entering Enhanced Care Management (ECM) (See *CM-011 Enhanced Care Management - Care Management & Transitions of Care*).
         ~~2.3.3.4.~~2.2.3.4. Children with Special Health Care Needs (CSHCN) (*UM-002 Coordination of Care*)

~~2.3.3.5.~~2.2.3.5. Pregnant and postpartum individuals (See ~~*UM-025*~~*CM-044 Guidelines for Obstetrical Services*)

~~2.3.3.6.~~2.2.3.6. Seniors and persons with disabilities who meet the definition of "high risk." (See *CM-008 SPD HRA - Survey and Interventions*)

~~2.3.3.7.~~2.2.3.7. Members who are identified as high risk

~~2.3.3.7.1.~~2.2.3.7.1. Prior to the DHCS Medi-Cal Connect ~~launch~~RSST (Risk Stratification, Segmentation, and Tiering) required implementation, the Alliance will use their own ~~Risk Stratification and Segmentation (RSS)~~RSST strategy.

~~2.3.3.7.2.~~2.2.3.7.2. After the ~~statewide RSS and risk tiers are available through the~~DHCS Medi-Cal Connect RSST is implemented, the Alliance will at minimum assess members who are identified as high-risk.~~The Alliance uses a Risk Stratification and Segmentation (RSS) process that incorporates DHCS requirements and available statewide RSS tools, including Medi-Cal Connect functionality, when available, to identify members at elevated risk and determine appropriate intervention.~~

~~2.3.3.8.~~2.2.3.8. In addition, CSHCN and those with LTSS needs receive an annual reassessment.

~~2.3.4.~~2.2.4. The Alliance or contracted PCP follows up on any positive assessment results.

~~2.4.~~2.3. The Alliance leverages a broad set of data sources to support PHM Program information gathering and inform Risk Stratification and Segmentation (RSS) as described in Understanding risk (See *PH-003 Risk Stratification and Segmentation (RSS) Process*).

~~2.5.~~2.4. The Alliance provides members three types of services and supports:

~~2.5.1.~~2.4.1. Care management programs including:

~~2.5.1.1.~~2.4.1.1. ECM (See *CM-011 Enhanced Care Management*)

~~2.5.1.2.~~2.4.1.2. CCM (See *CM-001 CCM Identification Screening Enrollment and Assessment*)

~~2.5.2.~~2.4.2. Basic Population Health Management (BPHM*) (*See *PH-002 Basic Population Health Management (BPHM)*) which includes the following services:

~~2.5.2.1.~~2.4.2.1. Access to primary care

~~2.5.2.2.~~2.4.2.2. Care Coordination, navigation and referrals across health and social services

2.4.2.3. S~~s~~haring and exchange of member information and medical records among~~by~~ providers and the Alliance.~~ MCP~~

~~2.5.2.3.~~2.4.2.4. Services provided by Community Health Workers (CHWs)

~~2.5.2.4.~~2.4.2.5. Wellness and prevention programs

~~2.5.2.5.~~2.4.2.6. Chronic disease programs

~~2.5.2.6.~~2.4.2.7. Programs focused on improving maternal health outcomes

~~2.5.2.7.~~2.4.2.8. Case management services for children under EPSDT

~~2.5.3.~~2.4.3. Transitional Care Services (TCS) ~~-~~(See *CM-034 Transitional Care Services*)

3. The Alliance uses Quality Measures and Key Performance Indicators (KPIs) to assess the overall implementation, operations, and effectiveness of all PHM programs and understand the impact on quality and equity.

3.1. Areas that are monitored include, but are not limited to BPHM, ECM, CCM, and TCS.
3.2. Quality Measures are reviewed annually based on DHCS guidance.
3.3. KPIs are developed based on DHCS guidance and monitored monthly with quarterly submissions to DHCS.

4. The Alliance takes action to reduce health care disparities through the following activities.
4.1. NCQA Health ~~Equity~~ Outcomes Accreditation identified HEDIS measures are stratified by race, ~~/~~ethnicity, language, sexual orientation, disability status and geographic classification and reviewed annually to determine if health care disparities exist.
4.2. At least annually, race, ~~/~~ethnicity, language, ~~, gender identity and/or~~ sexual orientation, disability status, and geographic classification data are reviewed to determine if health care disparities exist among:
4.2.1. ~~Two~~ Four ~~or more~~ valid HEDIS measures of clinical performance, by race and ~~/~~ethnicity.
4.2.2. One or more valid measures of clinical performance, such as HEDIS, by preferred language.
4.2.3. One or more measures of clinical performance, such as HEDIS, by ~~gender identity and/or~~ sexual orientation (when data becomes available).
4.2.4. One ~~-~~or more valid measure of clinical performance, such as HEDIS, by disability status (when data becomes available).
4.2.5. One or more valid measures of clinical performance, such as HEDIS, by geographic classification.
~~4.2.3.~~4.2.6. One or more valid measures of clinical performance, such as HEDIS, by an additional characteristic.
~~4.2.4.~~4.2.7. One or more valid measures of individual experience, such as CAHPS, by ~~race/ethnicity or preferred language~~a characteristic of the organization's choice.
4.3. Based on the assessment of health care disparities and language services, the Alliance annually:
4.3.1. Identifies and prioritizes opportunities to reduce health care disparities.
4.3.2. Identifies and prioritizes opportunities to improve the appropriateness or accessibility of care or services.
4.3.3. Implements at least one intervention to address a health care disparity and its root cause(s).
4.3.4. Implements at least one intervention to improve the appropriateness or accessibility of care or services.
4.3.5. ~~5.~~ Evaluates the effectiveness of an intervention to reduce a health care disparity and its root cause(s).
4.3.6. ~~6.~~ Evaluates the effectiveness of an intervention to improve the appropriateness or accessibility of care or services.
~~4.3. The Alliance identifies and prioritizes opportunities to reduce health care inequities and annually selects at least one intervention to address an inequity. This intervention is then evaluated for effectiveness.~~

DEFINITIONS / ACRONYMS

BPHM – Basic Population Health Management means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

CHA – Community Health Assessment means a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community.

CHIP – Community Health Improvement Plan (CHIP), also known as an Implementation Strategy, Implementation Plan, or Community Benefits Plan, is the output of the CHA. The CHIP is the action plan for how a community will use the data identified in the CHA to improve health outcomes.

~~**CHA** – Community Health Assessment means a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. Public health departments such as State, local, territorial, or Tribal develop CHAs to meet voluntary Public Health Accreditation Board (PHAB) standards and State Future of Public Health funding requirements. A variety of tools and processes may be used to conduct these population-level assessments. The essential feature, as defined by the PHAB, is that the assessment is developed through a participatory, collaborative process with various key sectors of the community.~~

~~**CHIP** – Community Health Improvement Plan means the output of the CHA when produced by public health departments (local, territorial, State, or Tribal) for PHAB accreditation, State Local Assistance Spending Plan funding allocation, and non-profit hospitals to meet federal and State requirements.~~

CSHCN – Children with Special Health Care Needs

CCM – Complex Case Management

CHW – Community Health Worker means an individual known by a variety of job titles, such as promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in All Plan Letter (APL) 22-016 or superseding APL.

DHCS - California Department of Health Care Services

D-SNP – Dual Eligible Special Needs Population

ECM – Enhanced Care Management means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

EPSDT - Early and Periodic Screening, Diagnostic, and Treatment (also known as Medi-Cal for Teens and Kids) means the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC sections 1396a(a)(43) and 1396d(a)(4)(B) and (r), 42 CFR section 441.50 *et seq*., and as required by W&I sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or Behavioral Health conditions.

IHA – Initial Health Appointment means an assessment that must be completed within 120 days of MCP enrollment or provider assignment for new Members and must include a history of the Member's physical and behavioral health, an identification of risks, an assessment of

need for preventive screens or services and health education, and a diagnosis and plan for treatment of any diseases.

KPI – Key Performance Indicators

Local Planning – Local Planning describes the requirements for MCPs to meaningfully participate in the Community Health Assessment (CHA) of Local Health Departments in its Service Area. The findings of the CHA collaboration will inform the annual PHM Strategy.

LHD – Local Health Department means a municipal, county, or regional public health department**.**

LTSS – Long-term Services and Supports means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS Programs, and includes carved-in and carved-out services.

Medi-Cal Connect – The PHM Service (also known as Medi-Cal Connect) means a data backed platform that collects and links Medi-Cal beneficiary information from disparate sources and performs Risk Stratification and Segmentation (RSS) and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.

MCP – Managed Care Plan

NCQA – National Committee for Quality Assurance

PCP – Primary Care Provider means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

PHM – Population Health Management means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

PHM Service – Population Health Management Services means a service that collects and links Medi-Cal beneficiary information from disparate sources and performs RSS and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.

PHM Strategy – means an annual deliverable that the Alliance must submit to DHCS requiring the Alliance to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

~~**PNA** – Population Needs Assessment means a multi-year process during which the Alliance will identify and respond to the needs of its members and the communities it serves by participating in the CHA of LHDs in its Service Area. The findings of the PNA/CHA collaboration will inform the Alliance's annual PHM Strategy.~~

RSS – Risk Stratification and Segmentation

RSST – Risk Stratification, Segmentation, and Tiering

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TCS – Transitional Care Services

AFFECTED DEPARTMENTS/PARTIES

Analytics
Case Management
Health Care Services
Member Services
Population Health and Equity
Provider Services
Quality Improvement
Alliance Provider Network
Alliance local health and community-based organizations

RELATED POLICIES AND PROCEDURES

CM-001 CCM Identification Screening Enrollment and Assessment
CM-008 SPD HRA - Survey and Interventions
CM-011 Enhanced Care Management - Care Management & Transitions of Care
CM-020 Health Information Form/Member Evaluation Tool (HIF/MET)
CM-034 Transitional Care Services
CM-044 Guidelines for Obstetrical Services
PH-002 Basic Population Health Management (BPHM)
PH-003 Risk Stratification and Segmentation (RSS) Process
PH-005 Population Assessment
QI-124 IHA Policy
UM-002 Coordination of Care
~~UM-025 Guidelines for Obstetrical Services~~

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

New Policy 9/19/2023

Updates: **3/19/2024**, 4/16/2025, **11/19/2025**, **TBD**

Blue = material updates

REFERENCES

DHCS CalAIM: Population Health Management (PHM) Policy Guide
DHCS 2023 MCP Amended Contract
DHCS 2024 MCP Contract

MONITORING

This Policy will be reviewed annually.

POLICY AND PROCEDURE

Policy Number	PH-002
Policy Name	Basic Population Health Management (BPHM)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	9/19/2023
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) and Alameda Alliance for Wellness (D-SNP) offer~~s~~ Basic Population Health Management (BPHM) as a part of its Population Health Management (PHM) Program. BPHM services include access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs) under the CHW benefit, wellness and prevention programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children under Early and Periodic Screening, Diagnosis and Treatment (EPSDT, Medi-Cal for Kids & Teens).

All Alliance members receive BPHM, regardless of their level of need. BPHM services comply with the California Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, the DHCS 2024 MCP Contract, or superseding APL or Contract, or Contract amendment. Where applicable, BPHM services meet the National Committee for Quality Assurance (NCQA) PHM standards and align with the DHCS Comprehensive Quality Strategy.

PROCEDURE

1. The Alliance ensures its members receive BPHM services.
   - 1.1. For members who are successfully engaged in primary care, the Alliance requires Primary Care Providers (PCPs) to be responsible for select care coordination and health education functions. For members who do not engage with a PCP, the Alliance assumes responsibility for provision of BPHM.
   - 1.2. For members enrolled in Enhanced Care Management (ECM), the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of their care management.
   - 1.3. For members who receive skilled nursing facility or other long term care services, BPHM services are provided by the facility physician or the member's assigned PCP.

When additional care coordination is needed, Alliance Long Term Care team provides BPHM services.

2. The Alliance ensures that all members have access to and are utilizing primary care by:
   ~~Incorporating available risk stratification, segmentation, and tiering information, including Medi-Cal Connect RSST data, as applicable, to identify members who may need BPHM outreach, care coordination, screening follow-up or referrer to services. The use of RSST is further described in policy *PH-003 Risk Stratification and Segmentation Process*.~~
   2.1. Identifying members who are not using primary care via utilization reports and enrollment data, which are stratified by race and ethnicity, and developing strategies to address utilization patterns.
   2.2. Ensuring members have appropriate, ongoing, and timely sources of primary care to meet the members' needs.
   2.3. Ensuring members are engaged with their assigned PCPs. For members who have been assigned a PCP but have not yet engaged with the PCP (e.g., assigned but not seen or lost to follow-up), the Alliance in coordination with PCP partners outreaches to the member.
      2.3.1. Sharing outreach reports with delegates and PCPs on assigned members requiring outreach and education on the importance of outreach to engage members in care.
      2.3.2. Sharing reports with PCPs on which members are due for an Initial Health Appointment.
      2.3.3. Monitoring HEDIS measures related to preventive health visits and screenings and addressing identified gaps.
   2.4. As needed, conducting member outreach to ensure connection with their PCP and BPHM services.
   2.5. Assisting members in making appointments, arranging transportation, and providing education on the importance of primary care or have not been seen within the last 12 months, particularly members less than 21 years of age.

3. The Alliance ensures child and youth members under 21 years of age receive EPSDT (Medi-Cal for Kids & Teens) services through their participation in BPHM, CCM, or ECM.
   3.1. Monitor utilization of preventive health visits and developmental screenings, including relevant HEDIS measures.
   3.2. Collaborate with community agencies and pediatric providers to address gaps in utilization through education, gap in care reports, and member incentives.
   3.3. Contact members through live calls and IVR who have gaps in care with reminders, education and assistance in scheduling needed visits.
   3.4. Track use of CHWs and BPHM care coordination efforts to ensure follow up and care coordination needs identified from screenings are delivered.
   3.5. Establish MOUs with First 5 programs and providers, WIC providers and every Local Education Agency (LEA) in Alameda County for school-based services to strengthen provision of EPSDT (Medi-Cal for Teens & Kids).

4. Alliance members may receive Care Coordination services and navigation and referrals across health and social services as needed. These services are described in Alliance Policy *UM-002 Coordination of Care*.

5. Alliance members are eligible for CHW services as described in Alliance policy *HCSP-001 Community Health Worker (CHW) Services.*

6. The Alliance offers comprehensive wellness and prevention programs that meet NCQA PHM standards, including the provision of evidence-based self-management tools, and align with the DHCS Comprehensive Quality Strategy's Clinical Focus Areas and Bold Goals. The Alliance offers all members wellness and prevention programs, in collaboration with Local Government Agencies (LGAs) as appropriate. The Alliance:
   6.1. Identifies specific, proactive wellness initiatives and programs that address member needs.
   ~~6.1.~~6.2. ~~Uses Local Planning and PHM Strategy activities, including collaboration with Local Health Jurisdictions, LGAs, community partners, and applicable Community Health Assessment and Community Health Improvement Program processes, to inform BPHM wellness, prevention, health education, and quality improvement priorities.~~ Annually reviews and updates wellness and prevention programs based on Local Planning participation and the DHCS Comprehensive Quality Strategy.
   ~~6.2.~~6.3. Addresses the NCQA required areas:
      ~~6.2.1.~~6.3.1. Healthy weight maintenance
      ~~6.2.2.~~6.3.2. Smoking and tobacco use cessation
      ~~6.2.3.~~6.3.3. Encouraging physical activity
      ~~6.2.4.~~6.3.4. Healthy eating
      ~~6.2.5.~~6.3.5. Managing stress
      ~~6.2.6.~~6.3.6. Avoiding at-risk drinking
      ~~6.2.7.~~6.3.7. Identifying depressive symptoms
   ~~6.3.~~6.4. Offers evidence-based disease management programs that comply with PHM NCQA standards including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, identify members for engagement, and seek to close care gaps for members participating in the interventions with a focus on improving equity and reducing health disparities. Disease Management Programs are described in the Alliance policy *CM-005 Disease Management Programs*.
   ~~6.4.~~6.5. Implements evidence-based initiatives to improve access to preventative health visits, developmental screenings, and services for members less than 21 years of age.
   ~~6.5.~~6.6. Implements evidence-based initiatives to improve pregnancy outcomes for women, including through 12 months postpartum.
   ~~6.6.~~6.7. Implements evidence-based initiatives to ensure adults have access to preventive care, as described in the DHCS contract and in compliance with all applicable state and federal laws.
   ~~6.7.~~6.8. Monitors the provision of wellness and preventive services by PCPs as part of our Site Review process. See Alliance policy *QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS).*
   ~~6.8.~~6.9. Develops health education materials, in a manner that meets Members' health education and cultural and linguistic needs. Health Education materials development is described in Alliance policy *HED-002 Health Education Materials.*

~~6.9.~~6.10. Implements evidence-based initiatives that are aimed at helping Members set and achieve wellness goals.

~~6.10.~~6.11. Submits wellness and prevention programs to DHCS for review and approval in a form and method prescribed by DHCS.

7. The Alliance continues to meet all requirements for pregnant and postpartum individuals, including covering the provision of all medically necessary services for pregnant ~~women~~and postpartum individuals, administering a comprehensive risk assessment tool comparable to the ACOG and CPSP standards, and providing appropriate follow-ups. Services for pregnant individuals are described in the Alliance Policy ~~*UM-025*~~*CM-044 Guidelines for Obstetrical Services*.

~~7. Pregnancy and Postpartum include proactive engagement and timely connection of members to necessary services and supports~~

8. The Alliance ensures members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities with whom the Alliance has or will have an executed MOU.

9. The Alliance provides the following services for members under 21:
   9.1. An Initial Health Appointment (IHA) within 120 calendar days of enrollment or within the AAP Bright Futures periodicity timeline for children ages 18 months and younger, whichever is sooner. (See *QI-124 IHA Policy*)
   9.2. Preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the AAP Bright Futures periodicity schedule, and immunizations specified by the Advisory Committee on Immunization Practices (ACIP) childhood immunization schedule. (See *QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services*).
   9.3. Ensures that all medically necessary services, including those that are not necessarily covered for adults, are provided as long as they can be Medicaid covered services. (See *QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services*).
   9.4. Coordinates health and social services for children between settings of care and across other MCPs and delivery systems. Specifically, MCPs must support children and their families in accessing medically necessary physical, behavioral, and dental health services, as well as social and educational services (See *UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens and Kids)*).

10. All BPHM services promote health equity and align with the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the U.S. Department of Health and Human Services that focus on the delivery of services in a culturally appropriate manner. The Alliance supports CLAS standards through its Cultural and Linguistic Services program (See *CLS-001 Cultural and Linguistic Services Program*).

11. The Alliance ensures non-duplication of BPHM services through documentation of participation in the Alliance Clinical Information System and reports that monitor member participation in BPHM services.

12. The Alliance does not delegate wellness and prevention programs to subcontractors or downstream subcontractors. However, the Alliance works with our delegated entities to ensure provision of wellness and prevention services, including services for members under 21, through:
    12.1. Sharing provider resources for wellness and prevention and clinical practice guidelines for preventive services.
        12.1.1. Listings for Alliance wellness programs and wellness and prevention education handouts, care books and links are accessible on the Provider and Live Healthy pages of the Alliance website, www.alamedaalliance.org.
        12.1.2. Resources are also shared in periodic provider webinars and at minimum yearly in the Provider Quarterly Packets.
        12.1.3. Updates to the United States Preventive Services Task Force A and B recommendations and Bright Futures guidelines are updated as available up to quarterly through the Provider Quarterly Packets and on the Alliance website.
    12.2. Monitoring provision of services through Population Health Management key performance indicators (KPIs) and program participation reports.
        12.2.1. The Alliance monitors all DHCS required Population Health Management KPIs monthly.
        12.2.2. The Alliance maintains reports of member participation in programs such as prenatal and parenting classes, breastfeeding support, referrals to smoking cessation and other wellness referrals and activities. See *HED-001 Health Education Program* for additional details.
    12.3. Sharing education and HEDIS performance data with delegated entities.
        12.3.1. The Alliance offers provider educational webinars on key HEDIS measures, including those relevant to members 21 and under. Webinars explain required services (such as dental care, developmental and cervical cancer screenings), best practices for successful performance on HEDIS measures, and Alliance wellness and prevention programs and resources.
        12.3.2. The Alliance also shares monthly HEDIS measure gap in care reports with all delegated entities.
        12.3.3. The Alliance also meets with delegates to share their HEDIS performance and offer quality improvement support to improve performance on HEDIS measures related to population health management and the quality bold goals, including measures relevant to members 21 and under. This information is communicated through articles in the Alliance provider newsletter.

DEFINITIONS / ACRONYMS

BPHM – Basic Population Health Management means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

CHA – Community Health Assessment means a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. ~~Community Health Assessment means a systematic examination of the health~~

~~status, needs, strengths, and disparities of a defined population that is used to identify priority health issues and assets iwthing a community.~~

CHIP – Community Health Improvement Plan (CHIP), also known as an Implementation Strategy, Implementation Plan, or Community Benefits Plan, is the output of the CHA. The CHIP is the action plan for how a community will use the data identified in the CHA to improve health outcomes. ~~means the output of the CHA when produced by public health departments (local, territorial, State, or Tribal) for PHAB accreditation, State Local Assistance Spending Plan funding allocation, and non-profit hospitals to meet federal and State requirements.Community Health Improvement Plan means a community-developed actionplan that identifies strategies, objectives, and activities to address priority needs identified through a CHA and improve health outcomes and health equity within a community.~~

CHW – Community Health Worker means an individual known by a variety of job titles, such as *promotores,* community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in All Plan Letter (APL) 22-016 or superseding APL.

CLAS – Culturally and Linguistically Appropriate Services

DHCS - California Department of Health Care Services

D-SNP – Dual Eligible Special Needs Plan

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HEDIS – Healthcare Effectiveness Data and Information Set means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

IHA – Initial Health Appointment means an assessment that must be completed within 120 days of MCP enrollment for new Members and must include a history of the Member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and a diagnosis and plan for treatment of any diseases.

IVR – Interactive Voice Response

KPI – Key Performance Indicator

Local Planning – Local Planning describes the requirements for MCPs to meaningfully participate in the Community Health Assessment (CHA) of Local Health Departments in its Service Area. The findings of the CHA collaboration will inform the annual PHM Strategy.~~CHA/CHIPs~~

LTSS – Long-term Services and Supports means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a

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Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS Programs, and includes carved-in and carved-out services.

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MCP – Managed Care Plan

MOU – Memorandum of Understanding

NCQA – National Committee for Quality Assurance

PCP – Primary Care Provider means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

PHM – Population Health Management means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

WIC – Special Supplemental Nutrition Program for Women, Infants, and Children

AFFECTED DEPARTMENTS/PARTIES

Case Management
Member Services
Provider Services
Quality Improvement

RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Services Program
CM-005 Disease Management Programs
CMP-400 Delegation Oversight
HCSP-001 Community Health Worker (CHW) Services
HED-002 Health Education Materials
QI-105 Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-124 Initial Health Appointment
QI-135 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens & Kids) Services
UM-002 Coordination of Care
UM-018 Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Teens and Kids)
~~UM-025~~CM-044 Guidelines for Obstetrical Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

New Policy: 9/19/2023
3/19/2024, 4/16/2025, **11/19/2025**, **TBD**

Blue = material updates

REFERENCES

DHCS CalAIM: Population Health Management (PHM) Policy Guide
DHCS 2024 MCP Contract

MONITORING

This Policy will be reviewed annually.

POLICY AND PROCEDURE

Policy Number	PH-003
Policy Name	Risk Stratification & Segmentation (RSS) Process
Department Name	Health Care Services Division
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	9/19/2023
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

1. Alameda Alliance for Health (Alliance) and Alameda Alliance for Wellness (D-SNP) ~~is~~are responsible for the development, implementation, and distribution of requirements for the Population Health Management (PHM) services and related activities to contracted entities, including risk stratification and segmentation grouping.
   - 1.1. Risk Stratification and Segmentation (RSS): The Alliance has developed an RSS methodology to separate all eligible members into risk groups or tiers based on all data sets currently available, including their clinical and behavioral health utilization, risk, and social needs characteristics and data. The risk stratification is used to highlight specific member needs and assists with determining the appropriate levels of care management or other services a member may need.
     - 1.1.1. Members will be stratified at least annually into one of the following risk tiers: 1. High Risk, 2. Medium-Rising Risk or 3. Low Risk
     - 1.1.2. The risk tiering logic will be assessed by the Alliance for validity and modified as needed to maximize efficacy, avoid and reduce biases, and prevent exacerbation of health disparities.
     - 1.1.3. Until the DHCS Medi-Cal Connect and RSS Methodology have been implemented, Alliance will utilize the RSS methodology it has developed to meet the requirements of the DHCS PHM Policy Guide, specifically using all data sources possible prior to the launch of the Medi-Cal Connect.
     - 1.1.4. RSS approach will comply with National Committee for Quality Assurance (NCQA) PHM standards, including integrating data sources to ensure the ability ~~to~~ of the Alliance to assess the needs and characteristics of all members. ~~and including at least 3 of the 7 NCQA data sources, and integrate data sources as defined in the 2023 MCP Contract.~~

Commented [JJ1]: Not sure why we have this here, are any contractors doing RSS?

Commented [GD2R1]: Downstream outreach and engagement activities perhaps.

Commented [JJ3]: Note:
-The Contract (is it from 2023 or 2024?) references the Policy Guide for data sources to integrate (already covered in bullet point above)
-The number of data sources total & number required to meet or partially meet in NCQA can change every year and they don't necessarily have to be used in RSS, just PHM functions in general

1.1.5. The Alliance considers findings from the ~~Population Needs Assessment (PNA)~~Local Planning activities and all members' behavioral, developmental, physical, oral health, and Long-Term Services and Supports (LTSS) needs, as well as health risks, rising-risks, and health-related social needs due to SDOH.

PROCEDURE

1. Risk Stratification and Segmentation prior to ~~Service~~ DHCS Medi-Cal Connect RSST ~~launch~~required implementation: The Alliance categorizes eligible members into risk tiers through the following mechanisms:
   1.1. The Alliance's RSS methodology includes utilizing predictive and status metrics from the Johns Hopkins ACG model to stratify members. Metrics may include probabilities for persistent high utilizers, high cost, and Inpatient/ED utilization. In addition, criteria utilized for Enhanced Case Management (ECM) and Complex Case Management (CCM) identification ~~is~~are incorporated into the methodology.
   1.2. The Alliance Analytics team consolidates the data sources into their reporting databases and runs the algorithm to assign a risk tier to each eligible member.
   1.3. As new member populations are implemented and/or new data sources are identified, the Alliance Analytics team will review and evaluate each data source to determine their impact on the methodology. Any potential impacts to the methodology will be reviewed with the Alliance Health Care Services (HCS) team. Any new data sources deemed to have an impact will be incorporated into the existing methodology logic.
   1.4. Any exclusion and/or non-duplication criteria as outlined in the DHCS PHM Policy Guide will be incorporated into the RSS logic, when applicable, and pending data source availability.

2. Data sources used in the RSS methodology, identification, and monitoring processes include the following for MC and IHSS members:

Data Source	Resourced From	RSS Incorporation
Managed care and fee-for-service (FFS) medical and dental claims and encounters (NCQA PHM 2 Element 1: Medical and behavioral claims or encounters)	1. Alliance claims data from HealthSuite (Alliance's claims and eligibility system) 2. Provider submitted encounter data stored in the Alliance reporting databases 3. DHCS monthly Plan Data Feed files	Data sources are used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology.
Pharmacy claims and encounters (NCQA PHM 2 Element 2: Pharmacy claims)	1. Alliance claims data from HealthSuite 2. Historical pharmacy data extracts from Alliance's Pharmacy Benefits Manager 3. Current pharmacy data extracts from DHCS (Service	Data sources are used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology.

Data Source	Resourced From	RSS Incorporation
	Dates 1/1/2022 forward)	
County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS) information available through the Short-Doyle/Medi-Cal and California Medicaid Management Information Systems (CA-MMIS) claims system (NCQA PHM 2 Element 1: Medical and behavioral claims or encounters)	1. Alameda County Behavioral Health (ACBH) utilization/encounter data for SMI (Note: Substance use disorder data not available without member consent) 2. DHCS monthly Plan Data Feed files	Data sources are used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology.
Electronic health records (EHR) (NCQA PHM 2 Element 5: Electronic Health Records)	1. Any EHR data received from providers/delegated entities are stored in the Alliance reporting databases.	Data sources are used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology.
Housing reports (e.g., through the Homeless Data Integration System (HDIS), Homelessness Management Information System (HMIS), and/or Z-code claims or encounter data) (NCQA PHM 2 Element 7: ~~Advanced Data Sources~~Health Information Exchanges)	1. HMIS data from the Alameda County Social Health Information Exchange (SHIE) 2. Z-code data from Alliance claims and encounter data 3. Z-code data from DHCS monthly Plan Data Feed files	Data sources are used in the determination of ECM eligibility/enrollment, which is a component in the RSS methodology.
Sexual orientation and gender identity (SOGI) information	1. Gender identity information from member eligibility data imported into HealthSuite from DHCS 834 files 2. SOGI information is currently unavailable.	Gender identity is used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology.

Data Source	Resourced From	RSS Incorporation
		Sexual orientation data to be included when the DHCS Medi-Cal Connect ~~/~~RSST methodology is available.
Admissions, discharge, and transfer (ADT) data (NCQA PHM 2 Element ~~7~~8: Advanced Data Sources)	1. ADT data received from facilities is stored in the Alliance reporting databases	Data is used to assist with real-time Care Management (CM) program referral.
Referrals and authorizations	1. Referral and authorization data from Alliance 's clinical system, TruCare	Data is used to assist with real-time CM program referral.
Race, ethnicity, and language information	1. Member eligibility data imported into HealthSuite from DHCS 834 files	Data is utilized for RSS methodology evaluation and monitoring identify disparities/gaps to inform health equity initiatives.
Screenings, assessments, and/or health appraisal results/data including but not limited to data collected in the Health Risk Assessments (HRAs) and HIF/METs (NCQA PHM 2 Element 4: Health Appraisals)	1. HRA data is collected and documented in Alliance 's clinical system, TruCare. 2. Internal care management assessments are also developed in TruCare to capture member information during care management activities. 3. HIF/MET data is collected and documented in TruCare.	Data from some TruCare assessments are utilized to identify homelessness for ECM eligibility/enrollment which is used in the RSS methodology. Data is also used to assist with real-time Care Management (CM) program referral. Additional data to be included in the RSS methodology when the DHCS Medi-Cal Connect RSST is available.
Disengaged member reports (e.g., assigned members who have not utilized any services)	1. Alliance internal reports that identify disengaged members.	Reports are utilized for monitoring and to identify potential QI initiatives. Data to be included in the RSS methodology when the DHCS Medi-Cal Connect RSST is available.
Laboratory test results (NCQA PHM 2 Element 3: Laboratory Results)	1. Laboratory test results are collected from Alliance's contracted laboratory	Laboratory test results are included in the calculation of HEDIS outcomes.

Data Source	Resourced From	RSS Incorporation
	providers. Data is stored in the Alliance databases and utilized by Alliance's NCQA certified HEDIS vendor, Cotiviti.	HEDIS outcomes are evaluated to provide direction in gaps in care and reduction of health disparities/biases. Data to be included in the RSS methodology when the DHCS Medi-Cal Connect RSST is available.
Social services reports (e.g., CalFresh, WIC, CalWORKs, In Home Services and Supports (IHSS))		Data to be included in the RSS methodology when the DHCS Medi-Cal Connect RSST is available.
MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment (MTOUD, also known as Mediations for Opioid Use Disorder), and other SUD; and other non-specialty mental health services information		Data to be included in the RSS methodology when the DHCS Medi-Cal Connect RSST is available.
Justice-involved data		Data to be included in the RSS methodology when the DHCS Medi-Cal Connect RSST is available.
Disability status		Data to be included in the RSS methodology when the DHCS Medi-Cal Connect RSST is available.
For members under 21, information on developmental and adverse childhood experiences (ACEs) screenings		Data to be included in the RSS methodology when the DHCS Medi-Cal Connect RSST is available.

3. Alliance Analytics team runs the RSS algorithm monthly to reflect new information received, including newly enrolled members, and update member risk tiers as necessary.
   3.1. Alliance also identifies any significant change in health status or member's level of care and occurrence of events or new information that may change a member's needs through

internal review activities, provider referrals and member self-referrals including referrals to CCM, ECM, Transitional Care Services (TCS), and Community Supports (CS).

3.2. Any necessary changes in RSS risk tier will be incorporated into the next monthly run.

3.3. The monthly member level risk tier information is stored in the Alliance databases for reporting, viewing, and historical purposes.

4. The Alliance uses risk tiers to:
   4.1. Identify members who require assessment. The Alliance assesses members upon enrollment and upon receipt of new information that the Alliance determines as potentially changing a member's level of risk and need.
   4.2. Connect all members, including those with rising risk, to an appropriate level of service, including but not limited to, care management programs, basic PHM, wellness and prevention services, and Transitional Care Services (TCS).
      4.2.1. Case Management staff use the monthly RSS report to assist in identifying higher risk members.
      4.2.2. Key delegates receive monthly RSS reports to assist in identifying higher risk members.
      4.2.3. The RSS report assists in identifying high risk members who will receive High Risk TCS.
      4.2.4. The RSS report also aids in identifying members for participation in the Alliance Disease Management programs.
   4.3. Monitor and improve the penetration rate of PHM programs and services, including, but not limited to, the percentage of members who require additional assessments who complete them as well as the connection of members to the programs and services they are eligible for.

5. On a monthly basis, the Alliance transmits a list of assigned members and their RSS risk tier via Secure File Transfer Protocol (SFTP) to each delegated provider as requested. This file is used to identify the appropriate level of care for the member.

6. The RSS methodology, key performance indicators and outputs will be continually evaluated to determine accuracy and effectiveness of the overall RSS model with the goal of addressing biases, reducing health disparities and improving outcomes.
   6.1. Alliance clinical staff participate in the creation and review of the RSS methodology.
   6.2. Reports and dashboards are developed to assist with monitoring and reviewing how the RSS methodology is performing overall and identification of any biases that may exacerbate health disparities.
      6.2.1. The Alliance maintains a Risk Stratification and Segmentation Dashboard to monitor our ~~RRS~~ RSS methodology and review our member assignment to tiers based on race/ethnicity and language.
      6.2.2. The Alliance maintains a HEDIS dashboard that reviews for disparities based on race/ethnicity, language, gender and age.
   6.3. Identified biases will be addressed by adjustment of the methodology as needed. This might include adding additional data sources, in particular data related to social determinants of health, or lowering the weight of identified problematic data sources.

7. After the DHCS Medi-Cal Connect RSST ~~and risk tiering~~ functionalities are available, the

Alliance will:

7.1. Utilize the Medi-Cal Connect RSST outputs ~~and tiers~~ to support statewide standardization and comparisons. The Medi-Cal Connect RSST will place each individual into a risk tier (i.e., high, medium-rising, or low).

7.2. Identify and assess member-level risks and needs and, as needed, connect members to services. The risk tiering will set a standard to identify members who require further assessment and connection to appropriate services.

7.3. Inform and enable member screening and assessment activities, including pre-populating screening and assessment tools.

7.4. Support member engagement and education activities.

7.5. Utilize local data sources or real-time data that could supplement identification of additional members for further assessments and services.

7.6. Not manually "override" a risk tier given by the Medi-Cal Connect RSST on a member, as these risk tiers will be used to ensure equity and accountability across the state.

7.7. Work with network providers to exercise judgment and shared decision-making with the member about the services a member needs, including through use of real-time information that may be available and through the assessment/reassessment process.

7.8. Utilize the Medi-Cal Connect risk tiers as a starting point for assessment, but not a requirement for or barrier to services.

7.9. Adhere to the data-sharing requirements as defined by the California Health & Human Services Agency Data Exchange Framework.

8. The IHSS line of business will continue to utilize the Alliance RSS methodology when the DHCS Medi-Cal Connect RSST is implemented for the Medi-Cal population.

DEFINITIONS / ACRONYMS

ACG	Adjusted Clinical Groups
CCM	Complex Case Management
CS	Community Supports
DHCS	Department of Health Care Services
D-SNP	Dual Eligible Special Needs Population
ECM	Enhanced Care Management
ED	Emergency Department
HCS	Health Care Services department
IHSS	In Home Support Services line of business
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PHM	Population Health Management
Local Planning	Local planning describes the requirements for MCPs to meaningfully participate in the Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) conducted by Local Health Jurisdictions (LHJs).
Medi-Cal Connect	Statewide technology service designed to support PHM Program

	functions
RSS	Risk Stratification and Segmentation
RSST	Risk Stratification, Segmentation, and Tiering
RUB	Resource Utilization Band
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
SMI	Serious Mental Illness
TCS	Transitional Care Services

AFFECTED DEPARTMENTS/PARTIES

Analytics
Health Care Services

RELATED POLICIES AND PROCEDURES

PH-001 Population Health Management (PHM) Program

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

New Policy 9/19/2023
Updates: **9/18/2024, 9/17/2025, TBD**

Blue = substantive updates

REFERENCES

DHCS APL22-024 Population Health Management Policy Guide
DHCS PHM Policy Guide

MONITORING

This policy will be reviewed annually.

POLICY AND PROCEDURE

Policy Number	PH-005
Policy Name	Population Assessment
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/21/2006
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) and Alameda Alliance for Wellness (D-SNP) ~~assesses~~assess the characteristics, health needs, and health-related social needs of ~~its~~ their member populations to identify ~~population level health and social needs,~~ disparities~~,~~ and opportunities to improve health outcomes. ~~of the Alliance local communities and members and to identify health disparities.~~

The Alliance ~~follows the Population Needs Assessment (PNA)~~meets Local Planning and PHM Strategy requirements defined in the DHCS All Plan Letter APL-23-021, the DHCS CalAIM: Population Health Management (PHM) Policy Guide, the DHCS 2024 Managed Care Plan (MCP) Contract, or superseding APL, DHCS policy guide, and/or amended contract~~or superseding APL, contract, or contract amendment~~. The Alliance meaningfully participates with Local Health Jurisdictions' (LHJs') Community Health Assessment (CHA) ~~process~~ and Community Health Improvement Plans (CHIP) process to deepen the Alliance's understanding of our members and strengthen our relationship with the communities we serve. This allows us to holistically identify the needs and strengths within member communities so that together with our community partners, we can more effectively and sustainably improve the lives of members and with fewer siloed approaches to population health management.

In addition, the Alliance conducts an annual NCQA population assessment of Medi-Cal and~~,~~ Group Care~~, and D-SNP members~~ following the National Committee for Quality Assurance (NCQA) Population Health Management accreditation requirements to assess the characteristics and needs, including social drivers of health, of its member population and relevant

subpopulations. For D-SNP members, the Alliance develops and submits a Model of Care (MOC) to CMS that includes a population ~~assessment~~description of the D-SNP membership. ~~T~~The Alliance provides demographic characteristics, health status information, and a description of health disparities faced by enrollees, differentiating between the general D-SNP population and the most vulnerable enrollees. ~~he Alliance conducts ongoing monitoring and annual evaluation of the D-SNP population to identify member needs, assess disparities, and inform program planning. Activities related quality improvement, health equity, and evaluation of population health outcomes are conducted in accordance with~~MOC submission, evaluation, and staff training requirements are covered in ~~P~~policies~~.~~ *QI-101 Quality Improvement Health Equity Program*, *QI-D-003 Model of Care Annual Evaluation Policy, and QI-D-005 DSNP MOC Staff Training*.

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Population analysis results are not used for underwriting or denial of coverage and benefits.

PROCEDURE

1. The Alliance meets the DHCS Local Planning ~~Population Needs Assessment (PNA)~~ requirement by meaningfully participating in the Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) conducted by Local Health Jurisdictions (LHJs). For the Alliance, the LHJs are Alameda County and City of Berkeley.
   - 1.1. Between 2024 and 2027, MCPs will work with each LHJ on their CHA/CHIP according to their current timeline. Starting in 2028, all LHJs will be expected to be on the same three-year cycle with the LHJ CHA or data refresh to be completed in December 2028 and the CHIP or data refresh to be completed by June 30, 2029.
   - 1.2. Meaningful participation will align with DHCS definitions and includes but is not limited to data sharing, contribution of resources, and stakeholder engagement.
     - 1.2.1. The Alliance will collaborate with other MCPs in the same service area (i.e., Kaiser for Alameda County) to coordinate the types of staffing/funding to be provided, what data is to be shared, ~~as well as~~and communications with the LHJs.
     - 1.2.2. ~~Between 2024 and 2027, the~~The Alliance ~~will begin sharing~~ shares data with LHJs to support the CHA/CHIP process.
       - ~~1.2.2.1. In 2024, priority areas will be identified from the list provided in the DHCS CalAIM: PHM Policy Guide.~~
       - ~~1.2.2.2.~~1.2.2.1. ~~Starting in Q2 of 2025 at the latest, data~~ Data will be shared as agreed upon with the LHJ in accordance with all applicable laws and data sharing agreements. Data will be de-identified and suppressed according to LHJ or Alliance organizational guidelines for public use in collaborative analysis.

1.2.3. The Alliance ~~will~~ contribute~~s~~ resources to support LHJs' CHA~~s~~/CHIP~~s~~ activities in the form of funding and/or in-kind staffing~~ starting on January 1, 2025~~.

The Alliance will work with LHJs to determine the types of resources to contribute~~ and, when applicable, other Medi-Cal Managed Care Plans in Alameda County.~~.

1.2.3.1. Resource ~~contribtuions~~contributions may support activities such as data analysis, stakeholder engagement, project management, community engagement, communications, or other CHA/CHIP-related activities.

1.2.3.2. Resource contribution decisions will be reported to DHCS via the annual PHM Strategy Deliverable submission.

~~1.2.3.2.~~ These Local Planning resource contributions are separate from, and do not count toward, any Community Reinvestment obligations~~ unless otherwise directed by DHCS~~.

~~1.3. The Alliance and LHJs collaborate on at least one shared and meaningful goal that is accompanied by an objective that is SMART (specific, measurable, achievable, realistic, and time-bound). The objective:~~

~~1.3.1. Aligns with DHCS' Bold Goals (as described in DHCS' Comprehensive Quality Strategy).~~

~~1.3.2. Supports a relevant LHD project that is currently being implemented or about to launch.~~

~~1.3.3. Has a start date prior to January 2024.~~

~~1.3.4.~~1.2.3.3. ~~Is achievable in 1-2 years.~~The Alliance collaborates with LHJs and other local partners to align PHM activities with CHA/CHIP priorities, DHCS Bold Goals, statewide population behavioral health goals, wellness and prevention priorities, healthy equity ac

~~1.4.~~1.3. The Alliance participates in stakeholder engagement.

~~1.4.1.~~1.3.1. Attend key CHA/CHIP meetings and/or serve on committees or subcommittees as requested by LHJs.

~~1.4.2.~~1.3.2. Engage the Alliance Community Advisory Committee.

~~1.4.2.1.~~1.3.2.1. Regularly report on involvement in and findings from CHAs/CHIPs.

~~1.4.2.2.~~1.3.2.2. Obtain input/advice on how to use findings to influence MCP strategies and workstreams related to Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.

~~1.4.2.3.~~1.3.2.3. Over time, work with LHJs to use the CAC as a resource for stakeholder participation in LHJ CHA/CHIPs.

2. The Alliance will complete a PHM Strategy Deliverable as required by DHCS to report on meaningful participation in CHA/CHIPs.

3. ~~The PNA~~ Local Planning findings are~~is~~ shared publicly and with the Alliance Community Advisory Committee, providers, and staff.
   3.1. When an LHJ publishes its CHA/CHIP, it will be published on the Alliance website with a brief paragraph on meaningful participation in the process.
   3.2. ~~PNA~~ Local Planning findings are shared with providers, fully delegated subcontractors, downstream fully delegated subcontractors, through presentations at the Quality Improvement Health Equity Committee meeting and provider communications distributed through quarterly provider visits and posted on the Alliance website.
   3.3. ~~PNA~~ Local Planning findings and action plans are shared via presentations at internal subcommittees and meetings with relevant Alliance departments for use in planning and guiding culturally and linguistically relevant programs and member communication.

4. Based on participation in the CHA/CHIP processes, the Alliance annually reviews and updates the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:
   4.1. Targeted health education materials for members
   4.2. Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services
   4.3. Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs
   4.4. Wellness and prevention programs

5. The Alliance develops an annual NCQA population assessment and uses the findings from ~~both~~ the population assessment, impact evaluation, and involvement in Local Planning ~~activities, CHA/CHIP priorities, PHM program evaluation results, applicable statewide population behavioral health goals a~~and ~~relevant~~ Behavioral Health Services Act County Behavioral Health Integrated Plans ~~local planning priorities and the PNA~~ to develop the Alliance NCQA Population Health Management Strategy.
   5.1. The NCQA population assessment assesses the characteristics and needs including social drivers of health, of its member population, NCQA-required subpopulations, and special populations.
   5.2. The NCQA population assessment collects race and ethnicity data using multiple sources such as enrollment and eligibility data and data collected during the health risk assessment (HRA). If the Alliance doesn't collect data on at least 80% of the population, data is estimated by indirect methods and validated. This data is used to assess and evaluate characteristics such as:
      5.2.1. Member demographics such as age, gender, racial and ethnic characteristics
      5.2.2. Cultural data such as primary language
      5.2.3. Health status, behaviors, and utilization trends
      5.2.4. Health disparities

5.2.5. Social determinants (drivers) of health (SDOH)
5.2.6. Member experience
5.2.7. Gaps in services

5.3. The Alliance uses reliable data sources to identify member health needs and health disparities. Data sources may include Alliance data, including data from subcontractors and downstream subcontractors such as:
5.3.1. Member demographic data
5.3.2. The most recently available member CAHPS survey results
5.3.3. HEDIS results
5.3.4. Medical and behavioral claims or encounters
5.3.5. Pharmacy claims
5.3.6. Laboratory results when available
5.3.7. Alliance program enrollment and participation data
5.3.8. Risk data
5.3.9. Advanced data sources as available

5.4. The Alliance electronic data system receives, stores, and retrieves individual level data on race, ethnicity, language, ~~and gender identity and~~ sexual orientation, disability status, and geographic classification when available.
5.4.1. The race/ethnicity data is rolled up into the Office of Management and Budget (OMB) categories.
5.4.2. The Alliance reports the HEDIS race, ethnicity, and diversity of membership measure if applicable.

DEFINITIONS/ACRONYMS

CAC – Community Advisory Committee
CAHPS – Consumer Assessment of Healthcare Providers and Systems is a survey asking health plan consumers about their health care experience. The tool is a product of the Agency for Healthcare Research and Quality.
CHA – Community Health Assessment, also known as a Community Health Needs Assessment (CHNA) in some circumstances, is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. Public health departments (state, local, territorial, Tribal) develop CHAs to meet voluntary Public Health Board Accreditation Board (PHAB) standards and State Future of Public Health funding requirements, and non-profit hospitals develop these CHNAs to meet federal and state requirements to obtain and maintain their tax-exempt status. A variety of tools and processes may be used to conduct these population-level assessments. The essential feature, as defined by the PHAB, is that the assessment is developed through a participatory, collaborative process with various key sectors of the community.

CHIP – Community Health Improvement Plan (CHIP; also known as Implementation Strategy, triennial public health plan, or Implementation Plan, or Community Benefits Plan) is the output of these population-level assessments (CHA or CHNA) CHA. The Community Health Improvement Plan is typically produced by public health departments (local, territorial, state or Tribal) for PHAB accreditation, State Local Assistance Spending Plan funding allocation, and non-profit hospitals to meet federal and state requirements.

CMS – Centers for Medicare & Medicaid Services

DHCS – Department of Health Care Services

D-SNP – Dual Eligible Special Needs Plan, a Medicare Advantage plan designed for individuals eligible for both Medicare and Medicaid, focusing on coordinated care for complex needs.

ECM – Enhanced Care Management

HEDIS – Healthcare Effectiveness Data and Information Set is a tool used by health plans in the United States. It measures performance on critical areas of care and service.

LHJ – Local Health Jurisdiction

Local Planning – Local Planning describes the requirements for MCPs to meaningfully participate in the Community Health Assessment (CHA) of Local Health Departments in its Service Area. The findings of the CHA collaboration will inform the annual PHM Strategy.

MCP – Managed Care Plan

Medi-Cal Connect – The PHM Service (also known as Medi-Cal Connect) means a data backed platform that collects and links Medi-Cal beneficiary information from disparate sources and performs Risk Stratification and Segmentation (RSS) and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.~~And c~~

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

NCQA – National Committee for Quality Assurance

PHM – Population Health Management is a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

PHM Strategy – Population Health Management Strategy means an annual deliverable that the Alliance must submit to DHCS requiring the Alliance to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

~~**PNA** – Population Needs Assessment means a multi-year process during which a Contractor will identify and respond to the needs of its Members and the communities it serves by meaningfully participating in the community health assessment (CHA) of Local Health Departments (LHDs)~~

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~~in the service area(s) where Contractor operates. The findings of the PNA/CHA collaboration will inform the Contractor's annual PHM Strategy.~~

SDOH – Social Drivers of Health (also known as Social Determinants of Health) are the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functions and quality-of-life outcomes and risk factors.

Subpopulations – A group of individuals within the membership that share common characteristics.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Community Stakeholders
Provider Network

RELATED POLICIES AND PROCEDURES

HED-001 Health Education Program
CLS-001 Cultural and Linguistics Program Description
QI-101 Quality Improvement Health Equity Program
QI-D-003 Model of Care Annual Evaluation Policy
QI-D-005 DSNP MOC Staff Training

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

11/21/2006, 1/1/2008, 12/2009, 2/26/2010, 12/23/2013, 1/22/2014, 5/20/2015, 6/16/2016, 5/25/2017, 5/3/2018, 3/21/19, 3/19/2020, 3/18/2021, 11/18/21, 3/22/2022, 3/21/2023, 3/19/2024, 4/16/2025
Policy moved from HED-003 to PH-005 **3/19/2024**, **11/19/2025**, **TBD**

Blue = material updates

REFERENCES

DHCS All Plan Letter 23-021 Population Needs Assessment and Population Health Management Strategy

DHCS CalAIM: Population Health Management (PHM) Policy Guide

DHCS 2024 Contract

42 CFR sections 438.206(c)(2), 438.330(b)(4), and 438.242(b)(2)

22 CCR sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), 53904(a)(3), and 53910.5(a)(2),

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MONITORING

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

POLICY AND PROCEDURE

Policy Number	QI-TBD
Policy Name	Member Data Collection, Race and Ethnicity– **HO2: Element A, Collection of Data on Race and Ethnicity**
Department Name	TBD
Department Officer	Chief Medical Officer
Policy Owner	TBD
Line(s) of Business	MCAL, IHSS, DSNP
Effective Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health shall collect, maintain, and analyze relevant demographic and health data to identify population-level disparities and support the design and delivery of inclusive, non-stigmatizing, patient-centered, culturally and linguistically appropriate, and accessible care and services.

PROCEDURE

Direct data collection will be conducted for all populations described below. Data will be obtained from the identified populations through the collection methods outlined in this policy to ensure comprehensive and representative demographic data.

If a member or patient is unable to provide demographic information directly due to age, cognitive impairment, communication limitations, or other functional incapacity, the organization may obtain the information from the member's or patient's legally authorized representative, caregiver, parent, or guardian. Information obtained through these sources will be considered direct data collection for purposes of demographic data collection and reporting.

1. Population Description

Medi-Cal: The Medi-Cal population includes economically disadvantaged children and adults, maternal population, seniors, and individuals with disabilities who qualify for California's Medicaid program residing in Alameda County. This population is racially, ethnically, and linguistically diverse and often experiences significant health disparities. Many Medi-Cal

members have complex medical, behavioral health, and social needs, including higher rates of chronic conditions, mental health needs, and unmet social determinants of health such as housing instability, food insecurity, discrimination, and limited access to transportation. Effective care for the Medi-Cal population requires culturally responsive, culturally competent, community-based, and coordinated services that address both clinical and non-clinical needs.

Group Care/IHSS (Commercial): The IHSS worker population includes individuals who provide in-home supportive care to seniors and people with disabilities, enabling them to remain safe in their homes and communities. IHSS workers often have physical and emotional demanding roles and may experience occupational risk factors such as musculoskeletal strain, stress, and exposure to communicable illnesses. Many workers face social and economic challenges, including low wages, inconsistent work schedules, language barriers, and limited access to healthcare and preventive services. Supporting the health and well-being of IHSS workers is critical to maintaining continuity of care for vulnerable populations.

D-SNP: The D-SNP population consists of individuals who qualify for both Medicare and Medicaid, including seniors and people with disabilities. This population frequently has complex health needs, including multiple chronic conditions, functional limitations, and behavioral health conditions. D-SNP members often experience socioeconomic challenges such as limited income, housing instability, food insecurity, discrimination, and limited access to transportation. Effective care for the D-SNP population requires integrated Medicare-Medicaid benefits, robust care coordination, and attention to social determinants of health to support improved outcomes and continuity of care.

If a response is requested and not provided, the Alliance will document the response as "Asked But No Answer" and make reasonable efforts to obtain information through future member interactions. During subsequent outreach, staff will explain the purpose of the data collection, how the information will be used, applicable privacy protections, and that providing the information is voluntary and will not affect eligibility, benefits, coverage, or services. Members will be offered the opportunity to provide the requested information, select "Prefer Not to Answer," or decline participation. All outreach attempts and member responses will be documented in the designated system of record.

Members' information is voluntary and can be self-reported at any time.

The Alliance collects member information directly from members through Case Management interactions and the Member Portal. Members may provide, verify, or update information during engagement with Case Management staff or electronically through the Member Portal. Information obtained through these channels is recorded in the appropriate system of record and maintained in accordance with applicable privacy and confidentiality requirements.

2. Member Data Collection

The Alliance obtains race and ethnicity information from external data sources, including the California Department of Health Care Services (DHCS), Public Authority enrollment and demographic records, and the Centers for Medicare & Medicaid Services (CMS). Race and ethnicity data received from these sources are received on an electronic 834-enrollment file.

The Alliance may also obtain updated race and ethnicity information directly from members through case management interactions or the member portal. When multiple sources are available, the Alliance maintains the most current information in accordance with established data governance processes.

The data will be collected using the following methods:

- Health Risk Assessment
- Member Portal

By whom:

- Alliance Case Management
- Alliance Member Portal

Direct data is collected directly from members through telephone interactions and the secure member portal. Telephone collection may occur during case management, care coordination, health assessments. Portal collection occurs when members voluntarily submit information through the Alliance's secure online member portal.

3. **Standardized Data Collection Script**

Staff shall use an approved script that:

- Introduces the purpose of data collection
- Emphasizes voluntariness and confidentiality
- Requests member self-identification of race and ethnicity
- Allows “decline to answer” or “prefer not to state” response option

4. Standardized Data Collection Direct Questions:

- **Alliance Health Risk Assessment**:
    - What is your race/ethnicity (select all that apply)?

- **Member Portal:**
    - “How do you best identify your race and ethnicity (select all that apply)?”

5. Data Storage

- All race and ethnicity data is stored in the Operational Data Store (ODS) and TruCare, our Case Management system of record.
- Data is maintained in accordance with privacy and security requirements

6. Data Imputation Process

If race/ethnicity data is collected for less than 80% of the population:

1. AAH applies imputation using:
    - Member ZIP code
    - U.S. Census and other validated datasets
2. Estimated values are assigned based on geographic demographic distributions

7. Validation of Imputed Data

- Direct data sources: Internal member-level data repository

- Indirect data sources: Nationally recognized datasets (e.g., Census)
- AAH validates methodology periodically to ensure accuracy and reliability

8. Data Standardization

- All race and ethnicity data are mapped to combine OMB 1997 standard categories.

DEFINITIONS / ACRONYMS

AAH: Alameda Alliance for Health
OMB: Office of Management and Budget
ODS: Operational Data Storage
DSNP: Dual Eligible Special Needs Plan
DTRR Daily Transaction Reply Report

AFFECTED DEPARTMENTS/PARTIES

Healthcare Services
Member Services
Quality Improvement
Health Equity
Medicare Operations
Information Technology
Analytics

RELATED POLICIES AND PROCEDURES

PH-005 Population Assessment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

New Policy: <AOC Approval Date>

REFERENCES

NCQA Health Outcomes2, Element A: Collection of Data on Race and Ethnicity

MONITORING

Policy will be reviewed annually.

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	QI-TBD
Policy Name	Member Data Collection, Language**— HO2: Element B, Collection of Data on Language**
Department Name	Quality Improvement Department
Department Officer	Chief Medical Officer
Policy Owner	Chief Medical Officer
Line(s) of Business	MCAL, D-SNP, and IHSS
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health will collect, maintain, and analyze relevant member demographic, language, and health related data to identify and reduce health disparities; advance health equity; and support the design, delivery, and evaluation of culturally responsive, culturally and linguistically appropriate, patient-centered, inclusive, and accessible care and services. The collection of this data enables the Alliance to better understand member needs, improve quality of care and health outcomes, monitor equitable access to services, and ensure all members receive respectful, affirming and non-stigmatizing care.

The Alliance is committed to ensuring that language data collection promotes member trust, supports effective communication, and facilitates compliance with NCQA Health Outcome Accreditation standards, federal and state regulations, and the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

PROCEDURE

The Alliance will collect direct data collection for all populations described below. Data will be obtained from the identified populations through the collection methods outlined in this policy to ensure comprehensive and representative demographic data.

If a member or patient is unable to provide demographic information directly due to age, cognitive impairment, communication limitations, or other functional incapacity, the organization may obtain the information from the member's or patient's legally authorized representative, caregiver, parent, or guardian. Information obtained through these sources will be considered direct data collection for purposes of demographic data collection and reporting.

1. **Population Description**

Medi-Cal: The Medi-Cal population includes economically disadvantaged children and adults, maternal population, seniors, and individuals with disabilities who qualify for California's Medicaid program residing in Alameda County. This population is racially, ethnically, and linguistically diverse and often experiences significant health disparities. Many Medi-Cal members have complex medical, behavioral health, and social needs, including higher rates of chronic conditions, mental health needs, and unmet social determinants of health such as housing instability, food insecurity, discrimination, and limited access to transportation. Effective care for the Medi-Cal population requires culturally responsive, culturally competent, communitybased, and coordinated services that address both clinical and nonclinical needs.

IHSS/Group Care (Commercial): The IHSS worker population includes individuals who provide in-home supportive care to seniors and people with disabilities, enabling them to remain safe in their homes and communities. IHSS workers often have physical and emotional demanding roles and may experience occupational risk factors such as musculoskeletal strain, stress, and exposure to communicable illnesses. Many workers face social and economic challenges, including low wages, inconsistent work schedules, language barriers, and limited access to healthcare and preventive services. Supporting the health and well-being of IHSS workers is critical to maintaining continuity of care for vulnerable populations.

D-SNP: The D-SNP population consists of individuals who qualify for both Medicare and Medicaid, including seniors and people with disabilities. This population frequently has complex health needs, including multiple chronic conditions, functional limitations, and behavioral health conditions. D-SNP members often experience socioeconomic challenges such as limited income, housing instability, food insecurity, discrimination, and limited access to transportation. Effective care for the D-SNP population requires integrated Medicare-Medicaid benefits, robust care coordination, and attention to social determinants of health to support improved outcomes and continuity of care.

If a response is requested and not provided, the Alliance will document the response as "Asked But No Answer" and make reasonable efforts to obtain information through future member interactions. During subsequent outreach, staff will explain the purpose of the data collection, how the information will be used, applicable privacy protections, and that providing the information is voluntary and will not affect eligibility, benefits, coverage, or services. Members will be offered the opportunity to provide the requested information, select "Prefer Not to Answer," or decline participation. All outreach attempts and member responses will be documented in the designated system of record.

Members' information is voluntary and can be self-reported or updated at any time.

The Alliance collects member information directly from members through Case Management interactions and the Member Portal. Members may provide, verify, or update information during engagement with Case Management staff or electronically through the Member Portal. Information obtained through these channels is recorded in the appropriate system of record and maintained in accordance with applicable privacy and confidentiality requirements.

2. Member Data Collection

The Alliance obtains language data information from external data sources, including the California Department of Health Care Services (DHCS), Public Authority enrollment and demographic records, and the Centers for Medicare & Medicaid Services (CMS). Language data received from these sources are received on an electronic 834-enrollment file.

The Alliance may also obtain updated language data directly from members through case management interactions or the member portal. When multiple sources are available, the Alliance maintains the most current information in accordance with established data governance processes.

The data will be collected using the following methods:

- Health Risk Assessment
- Member Portal

By whom:

- Alliance Case Management
- Alliance Member Portal

3. **Standardized Data Collection Script**
Staff shall use an approved script that:

- Introduces the purpose of data collection
- Emphasizes voluntariness and confidentiality
- Requests member self-identification of language
- Allows “decline to answer” response option

4. Standardized Data Collection Direct Questions:

- Alliance Health Risk Assessment Survey:
    - **a.** What is your preferred spoken language
    - **b.** What is your preferred written language
- Member Portal:
    - **a.** What is your preferred written language
    - **b.** What is your preferred spoken language

5. Data Storage

- All language data is stored in the Operational Data Store (ODS) and TruCare, our Case Management system of record.
- Data is maintained in accordance with privacy and security requirements

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DEFINITIONS / ACRONYMS

ODS - Operational Data Storage
IHSS - In Home Support Services

AFFECTED DEPARTMENTS/PARTIES

Healthcare Services
Member Services
Quality Improvement Health Equity
Medicare Operations

RELATED POLICIES AND PROCEDURES

PH-005 Population Assessment
CLS-008, Member Assessment of Cultural and Linguistic Needs

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENT

[List related documents]

REVISION HISTORY

[List revision dates starting with original effective date – this is the date that revisions were approved at AOC, and is a running list of approval dates from AOC]

REFERENCES

NCQA Health Outcomes2, Element B: Collection of Data on Language

MONITORING

The policy will be reviewed annually.

POLICY AND PROCEDURE

Policy Number	QI-TBD
Policy Name	Member Data Collection, Disability Status– **HO2: Element D, Collection of Data on Disability Status**
Department Name	Quality Improvement Department
Department Officer	Chief Medical Officer
Policy Owner	Chief Medical Officer
Line(s) of Business	MCAL, D-SNP, IHSS
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health will collect, maintain, and analyze relevant member demographic, disability status, and health related data to identify and reduce health disparities; advance health equity; and support the design, delivery, and evaluation of culturally responsive, patient-centered, inclusive, and accessible care and services. The collection of this data enables the Alliance to better understand member needs, improve quality of care and health outcomes, monitor equitable access to services, and ensure all members receive respectful, affirming and non-stigmatizing care.

PROCEDURE

Direct data collection will be conducted for all populations described below. Data will be obtained from the identified populations through the collection methods outlined in this policy to ensure comprehensive and representative demographic data.

If a member or patient is unable to provide demographic information directly due to age, cognitive impairment, communication limitations, or other functional incapacity, the organization may obtain the information from the member's or patient's legally authorized

representative, caregiver, parent, or guardian. Information obtained through these sources will be considered direct data collection for purposes of demographic data collection and reporting.

Population Description
The plan collects disability data using accessible, member-centered methods that support equitable participation. Members are offered multiple alternatives to report their disability status, including mailed written forms, telephonic outreach, and electronic or in person interactions, based on the member's preferred language and preferred communication method. Reasonable accommodation, such as extended response time, interpreter services, or assistance completing forms, are offered as needed. All outreach efforts and accommodations provided are documented to ensure accessibility, consistency, and compliance with applicable requirements.

Direct data collection will be conducted for all populations described below. Data will be obtained from the identified populations through the collection methods outlined in this policy to ensure comprehensive and representative demographic data.

Medi-Cal: The Medi-Cal population includes economically disadvantaged children and adults, maternal population, seniors, and individuals with disabilities who qualify for California's Medicaid program residing in Alameda County. This population is racially, ethnically, and linguistically diverse and often experiences significant health disparities. Many Medi-Cal members have complex medical, behavioral health, and social needs, including higher rates of chronic conditions, mental health needs, and unmet social determinants of health such as housing instability, food insecurity, discrimination, and limited access to transportation. Effective care for the Medi-Cal population requires culturally responsive, culturally competent, community-based, and coordinated services that address both clinical and non-clinical needs.

IHSS/Group Care (Commercial): The IHSS worker population includes individuals who provide in-home supportive care to seniors and people with disabilities, enabling them to remain safe in their homes and communities. IHSS workers often have physical and emotional demanding roles and may experience occupational risk factors such as musculoskeletal strain, stress, and exposure to communicable illnesses. Many workers face social and economic challenges, including low wages, inconsistent work schedules, language barriers, and limited access to healthcare and preventive services. Supporting the health and well-being of IHSS workers is critical to maintaining continuity of care for vulnerable populations.

D-SNP: The D-SNP population consists of individuals who qualify for both Medicare and Medicaid, including seniors and people with disabilities. This population frequently has complex health needs, including multiple chronic conditions, functional limitations, and behavioral health conditions. D-SNP members often experience socioeconomic challenges such as limited income, housing instability, food insecurity, discrimination, and limited access to transportation. Effective care for the D-SNP population requires integrated Medicare-Medicaid benefits, robust care coordination, and attention to social determinants of health to support improved outcomes and continuity of care.

2. Member Data Collection

The Alliance may obtains disability status data information directly from members through case management interactions or the member portal. When multiple sources are available, the Alliance maintains the most current information in accordance with established data governance processes.

The data will be collected using the following methods:

- Health Risk Assessment

By whom:

- Alliance Case Managers
- Alliance Member Portal

Direct data is collected directly from members through telephone interactions and the secure member portal. Telephone collection may occur during case management, care coordination, health assessments. Portal collection occurs when members voluntarily submit information through the Alliance's secure online member portal.

3. **Standardized Data Collection Script**

Staff shall use an approved script that:

- Introduces the purpose of data collection
- Emphasizes voluntariness and confidentiality
- Requests member self-identification of disability status
- Allows "Choose not to disclose at this time" response option

4. Standardized Data Collection Direct Questions:

- Alliance Health Risk Assessment:
    - Do you need help with any of these actions?

- Member Portal:
    - Disability Function
        - Do you need help with any of these functions? Check all that apply.
    - Disability Identity
        - Do you identify as having a disability?
        - How would you describe your health [function] challenge(s)? Check all that apply

5. Data Storage

- All disability function and identity data is stored in the Operational Data Store (ODS).
- Data is maintained in accordance with privacy and security requirements

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DEFINITIONS / ACRONYMS

Disability Function - An aspect of disability status that describes the relationship between an individual's body functions or structures and the presence or absence of difficulty participating in major life activities or activities for daily living.

Disability Identity - An aspect of disability that describes an individual's sense of identity or self.

Disability Status - A social construct that describes the interaction between an individual's contextual factors (e.g., physical environment, sense of identity or self and perception by others) and functioning (e.g., body functions and structures, participation in major life activities or activities for daily living).

D-SNP - Dual Eligible Special Needs Plan

IHSS - In Home Support Services

AFFECTED DEPARTMENTS/PARTIES

Member Services Department
Case Management Department
Community Health Initiatives Department
Population Health & Equity Department

RELATED POLICIES AND PROCEDURES

CLS-003- Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities

C&O-001- Community Relations and Outreach Activities

UM-045- Communication Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

[List related documents]

REVISION HISTORY

[List revision dates starting with original effective date – this is the date that revisions were approved at AOC, and is a running list of approval dates from AOC]

REFERENCES

NCQA Health Outcomes2, Element D: Collection of Data on Disability Status

MONITORING

The policy will be reviewed annually.

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POLICY AND PROCEDURE

Policy Number	QI-TBD
Policy Name	Member Data Collection, Sexual Orientation – **HO2: Element C, Collection of Data on Sexual Orientation**
Department Name	Quality Improvement Department
Department Officer	Chief Medical Officer
Policy Owner	
Line(s) of Business	MCAL, D-SNP, IHSS
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health will collect, maintain, and analyze relevant member demographic, sexual orientation, and health related data to identify and reduce health disparities; advance health equity; and support the design, delivery, and evaluation of culturally responsive, patient-centered, inclusive, and accessible care and services. The collection of this data enables the Alliance to better understand member needs, improve quality of care and health outcomes, monitor equitable access to services, and ensure all members receive respectful, affirming and non-stigmatizing care.

The Alliance's approach to collecting sexual orientation data is designed to be culturally sensitive, culturally competent, and non-stigmatizing for our members.

To support this effort, the Alliance has implemented evidence-based internal trainings focused on transgender, gender diverse or intersex (TGI) training and diversity, equity, and inclusion (DEI) training for staff.

PROCEDURE

1. Population Description

Direct data collection will be conducted for all populations described below. Data will be obtained from the identified populations through the collection methods outlined in this policy to ensure comprehensive and representative demographic data.

The Alliance will collect direct data on sexual orientation from all members who are 18 years or older from each line of business expressed below.

If a member or patient is unable to provide demographic information directly due to age, cognitive impairment, communication limitations, or other functional incapacity, the organization may obtain the information from the member's or patient's legally authorized representative, caregiver, parent, or guardian. Information obtained through these sources will be considered direct data collection for purposes of demographic data collection and reporting.

Medi-Cal: The Medi-Cal population includes economically disadvantaged children and adults, maternal population, seniors, and individuals with disabilities who qualify for California's Medicaid program residing in Alameda County. This population is racially, ethnically, and linguistically diverse and often experiences significant health disparities. Many Medi-Cal members have complex medical, behavioral health, and social needs, including higher rates of chronic conditions, mental health needs, and unmet social determinants of health such as housing instability, food insecurity, discrimination, and limited access to transportation. Effective care for the Medi-Cal population requires culturally responsive, culturally competent, community-based, and coordinated services that address both clinical and non-clinical needs.

IHSS/Group Care (Commercial): The IHSS worker population includes individuals who provide in-home supportive care to seniors and people with disabilities, enabling them to remain safe in their homes and communities. IHSS workers often have physical and emotional demanding roles and may experience occupational risk factors such as musculoskeletal strain, stress, and exposure to communicable illnesses. Many workers face social and economic challenges, including low wages, inconsistent work schedules, language barriers, and limited access to healthcare and preventive services. Supporting the health and well-being of IHSS workers is critical to maintaining continuity of care for vulnerable populations.

D-SNP: The D-SNP population consists of individuals who qualify for both Medicare and Medicaid, including seniors and people with disabilities. This population frequently has complex health needs, including multiple chronic conditions, functional limitations, and behavioral health conditions. D-SNP members often experience socioeconomic challenges such as limited income, housing instability, food insecurity, discrimination, and limited access to transportation. Effective care for the D-SNP population requires integrated Medicare-Medi-Cal benefits, robust care coordination, and attention to social determinants of health to support improved outcomes and continuity of care.

If a response is requested and not provided, the Alliance will document the response as "Asked But No Answer" and make reasonable efforts to obtain the information through future member interactions. During subsequent outreach, staff will explain the purpose of the data collection, how the information will be used, applicable privacy protections, and that providing the information is voluntary and will not affect eligibility, benefits, coverage, or services. Members will be offered the opportunity to provide the requested information, select "Prefer Not to Answer," or decline participation. All outreach attempts and member responses will be documented in the designated system of record.

Members' information is voluntary and can be self-reported or updated at any time.

The Alliance collects member information directly from members through Case Management interactions and the Member Portal. Members may provide, verify, or update information during engagement with Case Management staff or electronically through the Member Portal. Information obtained through these channels is recorded in the appropriate system of record and maintained in accordance with applicable privacy and confidentiality requirements.

2. Member Data Collection

The Alliance may obtain sexual orientation data directly from members through case management interactions or the member portal. When multiple sources are available, the Alliance maintains the most current information in accordance with established data governance processes.

Data Collection Method and by Whom:
The data will be collected using the following methods:

Data Collection Method	By Whom
Member Portal	Member
Health Risk Assessment	Case Management

3. Standardized Data Collection Script
Staff shall use an approved script that:

- Introduces the purpose of data collection
- Emphasizes voluntariness and confidentiality
- Requests member self-identification of sexual orientation data
- Allows "Choose not to disclose" response option

4. Standardized Data Collection Direct Questions:

- Alliance Health Risk Assessment survey:
  - What is your sexual orientation?

- **Member Portal:**
  - What is your sexual orientation?

5. Data Storage

- All sexual orientation data is stored in the Operational Data Store (ODS) and TruCare, our Case Management system of record.

- Data is maintained in accordance with privacy and security requirements

DEFINITIONS / ACRONYMS

D-SNP: Dual Eligible Special Needs Plan
ODS: Operational Data Storage
IHSS: In Home Support Services
CHW: Community Health Worker
TGI: Transgender, Gender Diverse & Intersex
DEI: Diversity, Equity & Inclusion

AFFECTED DEPARTMENTS/PARTIES

Member Services Department
Case Management Department
Community Health Initiatives Department
Health Equity Department
Population Health & Equity Department

RELATED POLICIES AND PROCEDURES

PH-005: Population Assessment
HE-001: Diversity, Equity and Inclusion (DEI) Training Program
HE-002: Transgender, Gender Diverse or Intersex (TGI) Cultural Competency Training

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

[List related documents]

REVISION HISTORY

[List revision dates starting with original effective date – this is the date that revisions were approved at AOC, and is a running list of approval dates from AOC]

REFERENCES

NCQA Health Outcomes2, Element C: Collection of Data on Sexual Orientation

MONITORING

The policy will be reviewed annually.

POLICY AND PROCEDURE

Policy Number	TBD
Policy Name	Geographic Classification– **HO2: Element F, Classification of Geographic Data**
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	TBD
Line(s) of Business	MCAL, D-SNP, IHSS
Effective Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

The purpose of this policy is to establish a standardized methodology for geographic classification of members to ensure consistent data collection, analysis, and reporting.

Geographic classification supports the organization's ability to assess access to care, utilization patterns, health outcomes, and health disparities across defined geographic areas, and informs equity-focused decision-making and reporting.

PROCEDURE

1. Identify Member Location
   - Determine the member's county.
   - Determine the member's ZIP code.
2. Assign NCHS Classification
   - Locate the member's county in the National Center for Health Statistics (NCHS) Urban-Rural Classification Scheme.
   - Assign the appropriate NCHS classification category.
3. Assign RUCA Classification
   - Match the member's ZIP code to the USDA Rural-Urban Commuting Area (RUCA) ZIP code dataset.
   - Assign the corresponding RUCA code.
4. Categorize RUCA Codes
   - Group RUCA codes into the following categories:
     - Metropolitan: Codes 1–3 (Urban)
     - Micropolitan: Codes 4–6 (Suburban)
     - Small Town: Codes 7–9 (Rural)
     - Rural: Code 10 (Rural)

5. Application of Classification
   - Utilize both NCHS and RUCA classifications to analyze geographic variation and identify health disparities across populations.

DEFINITIONS / ACRONYMS

NCHS (National Center for Health Statistics): A classification system used to categorize counties by urban-rural status based on population size and metropolitan characteristics.

RUCA (Rural-Urban commuting Area Codes): A classification system that categorizes geographic areas based on population density, urbanization, and commuting patterns at the ZIP code level.

AFFECTED DEPARTMENTS/PARTIES

Applies to all departments responsible for population health analysis, reporting, health equity, and quality improvement activities, including but not limited to:

- Quality Improvement
- Population Health Management
- Analytics / Data Reporting

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

New Policy: [List date policy initially approved at AOC]

REFERENCES

Health Outcomes 2: Collecting Member- or Patient-Level Data
- Element F: Classification of Geographic Data

CDC - www.CDC.gov - NCHS Urban-Rural Classification Scheme for Counties
USDA - www.ers.usda.gov – Rural Urban Commuting Area Codes | Economic Research Service

MONITORING

This policy will be reviewed annually.

POLICY AND PROCEDURE

Policy Number	LTC-001
Policy Name	Long Term Care Program
Department Name	Long Term Care (LTC)
Department Officer	Chief Medical Officer
Policy Owner	Director, Long Term Services and Supports
Line(s) of Business	MCAL, D-SNP
Effective Date	01/01/2023
Administrative Oversight Committee Approval Date	~~12/17/2025~~TBD

POLICY STATEMENT

This policy outlines the process for providing Long Term Care (LTC) services in the following settings:

- LTC Nursing Facilities (NF)-Freestanding and Hospital Based
- Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD)
- Subacute (SA) care facilities
- Pediatric Subacute (PSA) care facilities.

The Alliance shall authorize utilization of LTC facilities and associated services for their members when they are deemed medically necessary.

PROCEDURE

I. Review

1. When a request is received for Long Term Care, Alliance will review all requests for medical necessity as outlined in LTC-002, in alignment with the DHCS contract, DHCS Manual of Criteria, Chapter 7, DHCS All Plan Letters (APLs) and the DHCS PHM Policy Guide.

~~1.~~

~~2. The facility shall submit all needed documents to the Alliance LTC Department, which are not limited to:~~

- ~~Completed LTC Authorization Request Form (ARF)~~
- ~~Copy of denial letter from primary payor (if applicable)~~
- ~~MD Order for Level of Care~~
- ~~If requesting Continuity of Care (COC)~~
  - ~~Proof of a previous authorization or~~
  - ~~Documentation that member was there before they became effective with the Alliance~~
- ~~For Nursing facilities:~~
  - ~~Electronic Preadmission Screening Resident Review (PASRR) Level I Screening documentation of a positive or negative result~~
    - ~~If the member is positive, a Level 2 screening is needed~~
  - ~~Most recent Minimum Data Set (MDS), either full assessment for admission or the latest quarterly assessment for continued stay.~~
- ~~For Subacute facilities:~~
  - ~~6200 Form~~
- ~~For ICF/DD Facilities:~~
  - ~~HS 231~~
  - ~~DHCS 6013A~~
  - ~~IPP/ISP if available~~

~~3.~~2. Alliance members will only be placed at LTC facilities that are licensed and certified by the California Department of Public Health, (CDPH.)

a. Providers are contractually required to meet the Credentialing requirements of AAH, be subject to the Credentialing process and NCQA requirements set forth in the Provider Manual prior to providing any health care services to Members. Only credentialed Providers may provide health care services to Members.
b. AAH will ensure that if a Member needs adult or pediatric subacute care services, they are placed in a health care facility that is under contract for subacute care with DHCS' Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.

~~4.~~3. The Alliance shall maintain standards for determining levels of care and authorizing services for Medi-Cal services that are consistent with policies established by the Centers for Medicare and Medicaid (CMS) and with the criteria for authorizing Medi-Cal services specified in Title 22, CCR, Section 51003.

~~5.~~4. AAH will adhere to the timeliness of authorization requirements applicable to each category of LTSS facilities.

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a. **Urgent** Preservice requests for members transitioning from an acute hospital: 72 hours from request receipt date, may extend to 14 calendar days in order to obtain needed information for review
b. **Routine** Preservice requests/Extension Requests prior to expiration of previous authorization: ~~5 business~~7 calendar days, may extend to 14 calendar days in order to obtain needed information for review.
c. **Retrospective** Requests (after member has been admitted): 30 calendar days from date of request

~~6.~~5. The AAH is responsible for ensuring timely access to:
a. Routine and unusual specialty referral and access
b. Ancillary services in the LTC setting. The Alliance approves Authorization Requests for covered therapy services when necessary for a LTC Facility resident to attain or maintain the highest practicable physical, mental, or psychosocial functioning in accordance with the comprehensive resident assessment and individualized plan of care.
c. Covered medically necessary dental services. The Alliance ensures Members residing in the LTC setting receive the covered medically necessary dental services including care coordination as described in LTC Program Description.
d. Covered medically necessary behavioral health care services. The Alliance ensures Members residing in the LTC setting receive, and the facility must provide, the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
e. Standing referrals. The Alliance maintains a process to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with both the specialist, if any, and the Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or Specialty Care Center, (SCC).

II. Continuity of Care

For Members already residing in a LTC facility after January 1, 2023, that have transitioned to the Alliance, the Alliance ensures eligible members will have continued residency in the LTC facilities:

1. When medical necessity is met:
    - For up to 12 months for members who are currently residing in a SNF
    - For up to 24 months for ICF/DD facilities
    - For up to 6 months for subacute facilities

    This will be granted without having to be requested by the Member, authorized representative, or Provider in accordance with the requirements in APL 23-022, or any superseding APL. Members that

transition to the Alliance after 01/01/2024, will need to request continuity of care.

Following their initial 12-month continuity of care period, Members or their authorized representatives may request an additional 12 months of continuity of care pursuant to APL 23-022 Continuity of Care.

Additional procedures implemented are outlined in UM 036-Continuity of Care for Terminated and Non-Participating providers, and UM 059-Continuity of Care for Medi-Cal Beneficiaries Transitioning into Managed Medi-Cal.

2. By recognizing any services treatment authorization requests (TAR) made by DHCS for the member enrolled into the Alliance.

3. For Members residing in ICF/DD or Subacute facilities as of January 1, 2024, the Alliance ensures eligible Members will have continued residency in the facilities, conforming to the Continuity of Care requirements of APL 24-011 for ICF/DD. AAH will ensure that a Member's ICF-DD Home/SA/PSA will not change for at least 12 months while AAH works to bring the ICF-DD Home/SA/PSAs into the network. During this continuity of care period, AAH will automatically provide 12 months of continuity of care, with no need for the Member to request it, but may be granted for up to two years.

4. The Alliance provides continuity of care with an out-of-network or terminated provider, including NF, ICF-DD, and Subacute service providers, for up to 12 months when:
    a. The Alliance can determine that the Member has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider). An existing relationship means the Member has resided in an out-of-network NF/ICF-DD/SA/PSA at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance, unless otherwise specified in DHCS guidance.
    b. The provider is willing to accept the higher of the Alliance's contract rates or Medi-Cal FFS rates; and
    c. The provider meets the Alliance's applicable professional standards and has no disqualifying quality-of-care issues (W&I Code Section 14182.17 and APL 23-022).
    d. If a Member was residing in an out-of-network skilled nursing facility (SNF,) ICF/DD or Subacute facility when the Member transitioned into the Alliance, the Alliance shall offer the Member the opportunity to return to the out-of-network SNF/ICF-DD/Subacute facility after a medically necessary absence, such as a hospital admission. This requirement does not apply if the Member is discharged from the SNF/ICF-DD/Subacute facility into the community or a lower level of care.

5. ICF/DD services, continuity of care is automatically applied. Medical necessity is determined by documentation reflecting current care needs and recipient's prognosis by the Regional Center. The HS 231, DHCS 6013 A and Treatment Authorization Request (TAR) form (LTC TAR 20- 1) are considered sufficient information to determine medical necessity; however, if documentation is lacking, the AAH will request additional supporting documents to substantiate medical necessity.

6. AAH allows Members to stay in the same ICF-DD Home/SA/PSA under continuity of care if the Member chooses to continue living in the ICF-DD Home/SA/PSA and all of the following apply:
    - The ICF-DD Home/SA/PSA is licensed by CDPH;
    - SA/PSA facility is contracted or actively in the process of being contracted by DHCS' SCU
    - The ICF-DD Home/SA/PSA is enrolled as a Medi-Cal Provider;
    - AAH will pay the ICF-DD Home/SA/PSA payment rates that meet the state statutory requirements.
    - The ICF-DD Home/SA/PSA meets AAH's applicable professional standards and has no disqualifying quality-of-care issues.

III. Long Term Services and Supports (LTSS) Liaison

AAH has an LTSS liaison for the Long-Term Services and Supports (LTSS) Provider community. The LTSS liaison is not required to be credentialed or licensed but has the ability to support the LTC population's service needs. The Liaison is trained by AAH to identify and understand the full spectrum of Medi-Cal long-term institutional care, including payment and coverage rules. The LTSS liaison serves as a single point of contact for service providers in both a Provider representative role and to support care transitions, as needed. The LTSS liaison assists service providers in addressing claims and payment inquiries in a responsive manner and assists with care transitions among the LTSS Provider community to best support a Member's needs.

AAH has an identified LTSS Liaison and disseminated their contact information to their network providers. AAH will notify network providers of changes to LTSS liaison assignment expeditiously to ensure coordination and services offered to Members.

Starting in 2026, the LTSS Liaison also facilitates at least quarterly webinars/office hours for network providers who deliver LTC services. The webinars present updates on policies and procedures pertaining to LTC services and answer frequently asked questions, including but not limited to questions about payment/claims processes, authorization procedures, provider dispute resolution, appeals, care coordination, and transitional care services. Webinars are conducted virtually, allowing providers to ask live questions and participate via telephone or online teleconference. At least 30 days before each webinar, the Alliance notifies network providers via electronic

communication and publishes on the public Alliance website the date and time of the webinar, and the instructions for joining.

IV. Regional Center/ICF-DD Roles

Regional Center

AAH adheres to the requirements of the Lanterman Act, working with the Regional Center of the East Bay (RCEB) to ensure that Members obtain all rights to comprehensive services and supports to enable people to live more independent, productive, and fulfilled lives. Per the Lanterman Act, persons with developmental disability receive available services and supports to approximate the pattern of everyday living available to people without disabilities of the same age. Members, and where appropriate, their parents, legal guardian, or conservator, are empowered to make choices in all life areas. These include promoting opportunities for individuals with developmental disabilities to be integrated into the mainstream of life in their home communities, including supported living and other appropriate community living arrangements. In providing these services, Members and their families, when appropriate, participate in decisions affecting their own lives, including, but not limited to, where and with whom they live, their relationships with people in their community, the way in which they spend their time, including education, employment and leisure, the pursuit of their own personal future, and program planning and implementation.

AAH will coordinate and work with Regional Centers in the identification of services that will be provided to the Member by AAH. The goal is to reduce any duplication of effort or work between AAH and Regional Centers, and to ensure AAH is fully aware of the Member's needs and the services to be provided by AAH and Regional Centers. It is the Regional Centers' duty to ensure their members residing in ICF/DD Homes receive all services and supports identified in the IPPs. AAH will inform the Regional Centers of which services will be provided by AAH. The Memorandum of Understanding between RCEB and AAH that includes coordination for Members living in ICF/DD Homes supports this effort.

The Regional Center is the primary Case Manager and Care Coordinator for any member residing in an ICF/DD facility.

1. The Regional Center develops an Individualized Program Plan (IPP) for each individual with intellectual or developmental disabilities, based on the individual's person-centered goals and needs.
    a. The IPP serves as a contract between the Member and identifies all services and supports the Member needs and is entitled to receive and whether the Regional Center will provide, supervise, or pay for the service, or another agency will. The IPP includes all services and supports the Member needs, even if they will be provided by another sources, such as AAH. The IPP process centers on the individual, and if appropriate, the individual's parents,

legal guardian or conservator, or authorized representative. The individual may choose whomever they wish to take part in their IPP meeting.

b. Enrollment with AAH does not change a Member's relationship to the Regional Center; access to Regional Center services and to the current IPP process remains the same.

ICF/DD

1. An Individual Service Plan (ISP) is developed by the ICF/DD Home's interdisciplinary professional staff/team, and includes participation of the individual, direct care staff, and includes all relevant staff of other agencies involved in serving the individual. The ISP implements the requirements of the Regional Center's IPP and is based on a detailed individual developmental assessment which includes disabilities, developmental strengths, and the individual's needs. It includes active treatment goals. The ISP is completed 30 days following a transition to an ICF/DD Home.

V. Discharge Planning/Case Management

1. The Alliance maintains processes to support NF/ICF-DD/SA/PSA in the event of a change in Member's condition and discharge. A NF/ICF-DD/SA/PSA may modify its care of a Member or discharge the Member if the NF/ICF-DD/SA/PSA determines that the following specified circumstances are present:
    i. The NF/ICF-DD/SA/PSA is no longer capable of meeting the Member's health care needs;
    ii. The Member's health has improved sufficiently so that he or she no longer needs NF/ICF-DD/SA/PSA services; or
    iii. The Member poses a risk to the health or safety of individuals in the NF/ICF-DD/SA/PSA.

2. Facility Transitions:
    When transitioning Members to and from Skilled Nursing Facilities, ICF-DD, SA/PSA Facilities, AAH ensures timely Member transitions that do not delay or interrupt any medically necessary services or care by meeting the following requirements, at a minimum:

    i. Coordinate with facility discharge planners, care or case managers, or social workers to provide case management and Transitional Care Services during all transitions. For members with developmental disability, such coordination will include the Regional Center. (See CM-034 Transitional Care Services for a full description of the TCS program.)

    ii. Assist Members being discharged or Members' parents, legal guardians, or authorized representatives by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with In Home Supportive Services, (IHSS,) Community Supports, Long Term

Services and Supports, (LTSS,) and other Home and Community Based Services, (HCBS);

iii. Maintain contractual requirements for Skilled Nursing Facilities to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data, and incorporate MDS Section Q data into transition assessments;

iv. Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

v. Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

vi. Follow-up with Members, Members' parents, legal guardians, or authorized representatives, Regional Center, as appropriate, regarding the new care setting to ensure compliance with Transitional Care Services requirements.

3. The Alliance Pharmacy Team will work with all LTC facilities to coordinate medication coverage.

4. AAH provides Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation to Members, including those residing in a SNF/ICF/SA, in accordance with the DHCS contract and APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses, or any superseding APL. This includes providing NEMT services if the Member is being transferred from an emergency room or acute care hospital to a SNF/ICF/SA, without prior authorization. For covered services requiring recurring appointments, AAH provides authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months. The Member must have an approved Physician Certification Statement form authorizing NEMT by the Provider. Day Program and related transportation (referenced in the ICF/DD State Plan Amendment (SPA) will continue to be provided by ICF/DD Homes and are not the responsibility of AAH. AAH also coordinates medically necessary drugs or medications on behalf of the Member.

~~5.~~ The Alliance has implemented a Population Health Management (PHM) program that ensures all Medi-Cal managed members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), Transitional Care Services, (TCS,) care management programs, and Community Supports. Through the implementation of BPHM, which is available to all Members regardless of level of need, The Alliance ensures members have access to needed services and programs, including primary care.

5.

6. As part of the PHM Program, AAH provides TCS when all Members are admitted discharged, or transferred from facilities, including SNFs, ICF-DD's, and Subacute facilities. AAH also ensures that all TCS are completed for all high-risk Members, (which includes members in LTCs,) and includes assigning a single point of contact, referred to as a care manager, to assist Members throughout their transition and ensure all required services are complete. Coordination of care for members in ICF-DD facilities will include Regional Center case managers. AAH and assigned care managers ensure that Member transitions to and from a SNF/ICF/SA are timely and do not delay or interrupt any medically necessary services or care, and that all required transitional care activities are completed. The Alliance provides Transitional Care Services to include:
    1. Timely authorizations for all Members
    2. Awareness of when all Members are admitted, discharged, and transferred
    3. Provide Transitional Care Services for all high-risk Members, including assigning a Care Manager to assist Members throughout their transition. A full description of the TCS program is in CM-034 Transitional Care Services.

Care management beyond transitions consists of two programs: (1) Complex Care Management (CCM) and (2) Enhanced Care Management (ECM). If a member is enrolled in either CCM or ECM, TCS is provided by the Member's assigned care manager. AAH also continues to provide all elements of BPHM to Members enrolled in care management programs. Members receiving long term services and supports (LTSS), including SNF/ICF-DD/Subacute services, are one of the groups considered to be "high risk" regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner. Members living in ICF/DD/SA Homes are eligible for basic PHM, TCS, and TCM as applicable. While they are not currently eligible for ECM, if there are other individual care needs or concerns, their needs can be reviewed for consideration. If a member is transitioning out of an ICF-DD Home/SA/PSA, the restriction of duplicative service is removed, and the Member is assessed to determine need/eligibility for ECM services.

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VI. Quality Monitoring

The Alliance maintains a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided, to include collecting quality assurance and improvement findings from CDPH, (and for SA/PSA, from SCU), to include, but not limited to, survey deficiency results, site visit findings, and complaint, and potential quality issue findings.

1. The AAH QAPI program incorporates:

a. Contracted NF/SA/PSA's QAPI programs, including the 5 key CMS elements:
    (1) Design and Scope
    (2) Governance and Leadership
    (3) Feedback, Data Systems and Monitoring
    (4) Performance Improvement Projects
    (5) Systematic Analysis and Systematic Action

~~b. Monitoring of LTC measures per the Managed Care Accountability Set (MCAS) of claims data for NF/SA/PSA residents, including but not limited to emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions. AAH supplies WQIP data via a template provided by DHCS on a quarterly basis or as requested~~

~~c.~~b. Mechanisms, such as investigation of Potential Quality Issues, to assess the quality and appropriateness of care furnished to enrollees using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan.

~~d.~~c. Efforts supporting Member community integration

~~e.~~d. Compliance with DHCS and CDPH efforts to prevent, detect, and remediate identified critical incidents through reporting of incidents to the Compliance Department

2. The Alliance reports on LTC measures per the Managed Care Accountability Set (MCAS) of performance measures and submits QAPI program reports on an annual basis to DHCS through the External Quality Review Organization (EQRO). AAH will adhere to quality and enforcement standards in APL ~~19-017~~24-004 and ~~APL 23-012, including APL 24-009 Skilled Nursing Facilities – Long-term care benefit standardization and transition of members to managed care, APL 24-010: Subacute Care Facilities – LTC Benefit Standardization and Transition of Members to Managed Care, and APL 24-011: ICF/DD – LTC Benefit Standardization and Transition of Members to Managed Care respectively,~~APL 25-007, or any superseding APLs.

3. AAH monitors quality and appropriateness of care provided to Members who reside at contracted ICF/DD Homes through review of compliance findings and data from the California Department of Public Health (CDPH) and service delivery findings from the Regional Centers through the AAH and Regional Centers' executed Memoranda of Understanding as part of the quality assurance program.

4. Upon DHCS request, AAH will submit quality assurance reports with outcome and trending data.

DEFINITIONS / ACRONYMS

1. **Skilled Nursing Facility (SNF)** means any institution, place, building, or agency which is licensed as a skilled nursing facility by the Department or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a skilled nursing facility) and has been certified by the Department for participation as a skilled nursing facility in the Medi-Cal program. This term includes "skilled nursing home," "convalescent hospital," "nursing home," or "nursing facility."
~~1.~~
2. **Nursing Facilities** are defined by DHCS as:
    a. Freestanding Skilled Nursing Facilities Level-B (FS/NF-B),
    b. Adult Freestanding Subacute Facilities Level-B (FSSA/NF-B),
    c. NF-Bs designated as
        i. Institutions for Mental Diseases (IMD),
        ii. Distinct Part Pediatric Subacute (DP/PSA) and
        iii. Freestanding Pediatric Subacute Facilities Level B (FS/PSA).
        ~~iii.~~
3. **Subacute Facilities** provide a level of care needed by a member who does not need hospital acute care but who requires more intensive skilled nursing care than is provided to most patients in a SNF. Criteria for Subacute Services is in section 7.2 of the Medical Provider Manual. Subacute care patients are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care. Adult subacute care is a level of care that is defined as comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process.
~~3.~~
4. **Pediatric Subacute Care** Services are the health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

~~4.~~

5. **Intermediate Care Facilities/Developmental Disability (ICF/DD)** are services provided in hospitals, skilled nursing facilities or intermediate care facilities for individuals with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center requiring skilled care or observation on an ongoing intermittent basis and 24-hour supervision.
    a. Members eligible for Regional Center are members who:
        i. Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care.
        ii. Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.
        iii. Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.
    b. With respect to services furnished to individuals under age 65, Intermediate Care services may include services in a public institution (or distinct part

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thereof) for members with a developmental disability or persons with related conditions only if:

i. The primary purpose of such institution (or distinct part thereof) is to provide a program of health or rehabilitative services for individuals with intellectual disabilities and such institutions meet standards as may be prescribed by the United States Department of Health and Human Services.
ii. The individual with intellectual disabilities with respect to whom a request for payment is made has been determined to need and is receiving active treatment under such a program.
iii. Payment for intermediate care services to any such institution (or distinct part thereof) will not be used to displace with Federal funds any non-Federal expenditures that are already being made for persons with intellectual disabilities.

AFFECTED DEPARTMENTS/PARTIES

1. Long Term Care
2. Member Services
3. Utilization Management
4. Claims Department
5. Provider Relations
6. Quality Management
7. Grievance and Appeals
8. Case Management

RELATED POLICIES AND PROCEDURES

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LTC-002 – Authorization Criteria
LTC-003 – LTC Case Management Identification and Enrollment
LTC-004 – LTC Bed Hold and Leave of Absence
UM-057 – Authorization Request
CM-034 – Transitional Care Services
CM-001-CCM Identification Screening, Enrollment, and Identification
CM-010-ECM Enrollment
CM-011-Enhanced Care Management
CS-001- Community Supports-Oversight, Monitoring and Controls

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

02/21/2023, 3/19/2024, 01/01/2025, **4/16/2025**, **12/17/2025**, **TBD**

Blue = material updates

REFERENCES

Title 22, CCR, Section 51003
Title 22, California Code of Regulations (CCR), §§ 51120, 51120.5, 51121, 51123,51124, 51124.5, 51124.6, 51215, 51118 and 51212, 51334,51335, 51535.1, 51335.5, 51335.6

Welfare and Institutions Code (W&I) Section 14186.3(c)(5)
W&I Code Section 14186.1(c)(4)

Health & Safety Code Sections 1371– 1371.39
~~W&I Code Section 14186.1(c)(4)~~
~~Title 22, CCR, Sections 51535 and 51535.1.~~
Department of Health Care Services (DHCS) and Alameda Alliance for Health Contract
Lanterman Developmental Disabilities Services Act
~~Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services~~
~~Alliance Policy EE.1135: Long Term Care Facility Contracting~~
~~AAH Policy – Grievance and Appeals~~
~~Claims Policy – Provider Disputes Resolution~~
~~The Alliance Provider Manual~~
~~The Alliance Utilization Management Program~~
Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates ~~and Revised Notice Templates and Your Rights~~
DHCS APL 23-022: Continuity of Care
DHCS APL 26-010 "Skilled Nursing Facilities - Long Term Care Benefit Under Managed Care"
DHCS APL 26-011 "Subacute Care Facilities - Long Term Care Benefit Under Managed Care"
DHCS APL 26-012 "Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefit Under Managed Care"
~~Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division~~
~~Title 22, California Code of Regulations (CCR), §§ 51120, 51120.5, 51121, 51123,51124, 51124.5, 51124.6, 51215, 51118 and 51212, 51334,51335, 51535.1, 51335.5, 51335.6,~~
~~The Medi-Cal Provider Manual, Part 2 Long Term Care, Subacute Care Programs: Level of Care for Adults and Children~~ DHCS LTC Provider Manual
Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services
~~Lanterman Developmental Disabilities Services Act~~
~~Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR 51003(e)~~
~~DHCS Contract Exhibit A Attachment III, section 5.3.7 Services for all members.~~
~~DHCS All Plan Letter (APL) 24-009 Skilled Nursing Facilities Long Term Benefit Standardization and Transition of Members to Managed Care~~
~~DHCS All Plan Letter (APL) 24-010 Subacute Care Facilities Long Term Care Benefit Standardization and Transition of Members to Managed Care~~

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~~DHCS APL 24-011 Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care~~

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MONITORING

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

POLICY AND PROCEDURE

Policy Number	LTC-002
Policy Name	Authorization Process and Criteria for Admission, Continued Stay, and Discharge from a Long-Term Care Facility
Department Name	Long Term Care
Department Officer	Chief Medical Officer
Policy Owner	Director, Long Term Services and Supports
Line(s) of Business	MCAL, D-SNP
Effective Date	01/01/2023
Administrative Oversight Committee Meeting	~~5/20/2026~~TBD

POLICY STATEMENT

This policy outlines the requirements for reviewing and processing Long Term Care (LTC) Authorization requests for a Member's admission to, continued stay in, or discharge from:

- Nursing Facility Level A (NF-A)- Freestanding and Hospital Based
- Nursing Facility Level B (NF-B)- Freestanding and Hospital Based
- Intermediate Care Facility-Developmental Disability (ICF/DD)
- Subacute Facilities (SA)
- Pediatric Subacute Facilities (PSA)

The Alliance shall authorize utilization of LTC facilities and associated services for their members when they are deemed medically necessary.

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PROCEDURE

I. Medical Necessity Review

1. When a request is received for Long Term Care within 90 days from the date of admission, Alliance will review the requests for medical necessity as outlined in the

DHCS contract, DHCS Manual of Criteria, Chapter 7, DHCS All Plan Letters (APLs) and the DHCS PHM Policy Guide.

2. If a request is received for Long T~~t~~erm Care after 90 days from the date of admission, Alliance will deny the request per P&P ~~the provider manual~~UM-057, unless ~~there was an extenuating~~exception criteria~~-~~ is met~~circumstance~~.

3. Requests for reauthorization should be submitted to the Alliance LTC Department at least twenty-four (24) hours prior to the expiration of the active LTC authorization. The facility may submit a reauthorization request using the ~~ARF~~ Post Acute Authorization Request form up to thirty (30) calendar days prior to the expiration of the active authorization. The request~~s~~ shall include all required documents and sufficient documentation to justify the level of care and continued stay.

4. The facility shall submit all needed documents to the Alliance LTC Department, including but ~~which are~~ not limited to:
~~4.~~

- Completed ~~LTC Authorization Request Form (ARF)~~Post Acute Authorization Form
- Copy of denial letter from primary payor (if applicable)
- MD Order for Level of Care
- If requesting Continuity of Care (COC)
    - Proof of a previous authorization or
    - Documentation that member was there before they became effective with the Alliance
    - ~~o~~
- For Nursing facilities:
    - ~~Electronic~~ Preadmission Screening and Resident Review (PASRR) Level I Screening documentation of a positive or negative result
        - If the ~~member~~ Level I screening is positive, completed ~~a~~ Level 2 screening documentation is also ~~needed~~required
        - **NOTE:** Nursing facility must receive completed PASRR documents prior to admission. 42 CFR Section 483.122 bans payments for nursing facility services when the PASRR process has not been completed.
    - Most recent Minimum Data Set (MDS), either full assessment for admission or the latest quarterly assessment for continued stay.
    - ~~o~~
- For Subacute facilities:
    - DHCS 6200/6200A Form
    - Preadmission Screening and Resident Review (PASRR) Level I Screening documentation of a positive or negative result
        - If the Level I screening is positive, completed Level 2 screening documentation is also required

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- ~~o~~ **NOTE:** Subacute facilities must receive completed PASRR documents prior to admission. 42 CFR Section 483.122 bans payments for Subacute Care Facility services when the PASRR process has not been completed.

- For ICF/DD Facilities:
  - HS 231 – Certification for Special Treatment Program Services (the Alliance accepts the HS 231 as evidence of the Regional Center's determination that the Member meets ICF/DD Home level of care)
  - DHCS 6013A – Medical Review/Prolonged Care Assessment Form
  - Individualized Program Plan (IPP) developed by Regional Center – if available~~P~~
  - ~~P/~~Individual Service Plan (ISP) developed by ICF/DD Home ~~SP – if available~~required for reauthorizations

5. If the request does not contain all the needed documentation, the LTC Coordinator will attempt 2 phone calls and a fax notification to obtain the requested information ~~(RFI)~~ from the facility. After 3 attempts, ~~Then~~ the coordinator will send ~~it~~ the request to the LTC Nurse for review.
~~5.~~
6. The ~~Once the~~ LTC nurse ~~receives the request, they will~~ reviews available information to determine whether the services are ~~for~~ medical necessary~~ity~~. If there is clinical information missing that inhibits the nurse's ability to perform a medical necessity ~~is crucial to the~~ review, ~~they~~ the nurse will ~~delay~~ delay the authorization decision ~~in order~~ to obtain the needed information, ~~if allowed by~~in compliance with regulatory timeframes~~turnaround time regulations~~.

   a. The delay notification will be sent to the facility and the member. The notification will include the reason for the delay, the information needed, the date a final decision will be made by, and all the required attachments per DHCS APL 21-011, including the appeal and grievance rights.

7. If the LTC nurse receives sufficient information to approve an authorization based on meeting medical necessity criteria, written notification of the approval is sent to the facility within 24 hours of the decision, and within 2 business days to the member, not to exceed turnaround time requirements. Approved date ranges may vary and can be granted for up to two years per authorization request, depending on the Member's condition and at the discretion of the reviewer.

~~7.~~8. If the LTC Nurse ~~is unable to~~ cannot approve the request due to insufficient documentation or ~~for~~ because the requested service does ~~not~~ meet ~~ing~~ Medical Necessity criteria, the LTC Nurse will refer the ~~authorization~~ request to the Medical Director for review.

   a. After the Alliance's Medical Director, or physician designee, reviews the request and ~~determines the decision~~makes a final decision, the written

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notification of that decision will be sent to the facility within 24 hours of the decision and within 2 business days to the member, not to exceed turnaround time requirements.

b. If an adverse determination is made, t~~T~~he notification will include:
   i. The reason for the denial in clear and concise language
   ii. The criteria used to make the determination
   iii. The option for the treating provider to discuss the decision with the AAH provider that made the determination
   iv. The name and phone number of the reviewing physician
   v. All required attachments per DHCS APL 21-011.

~~8.~~ Referrals for Discharge Planning, Care Coordination, Enhanced Care Management (ECM), Case Management (CM), Community Supports (CS), and Social Work (SW) will be made as needed.

9.

~~9.~~10. AAH will adhere to the timeliness of authorization requirements applicable to each category of LTSS facilities.

a. **Urgent** Preservice requests for members transitioning from an acute hospital: 72 hours from request receipt date, may extend to 14 calendar days in order to obtain needed information for review.
b. **Routine** Preservice requests/Extension Requests prior to expiration of previous authorization: 7 calendar days, may extend to 14 calendar days in order to obtain needed information for review.
c. **Retrospective** Requests (after member has been admitted): 30 calendar days from date of request

~~2.~~ **II. Internal Monitoring**

1. The LTC Department, on a routine basis, reviews:

~~b.~~a. Turnaround Time reports

~~d.~~b. ER and Readmission Data

~~f.~~c. Results from monthly file audits which include the timeliness of authorizations, criteria applied appropriately, appropriate member and provider notification, and the quality of the denial language.

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~~h.~~d. Complaints and grievances to identify issues and trends that will direct the development of corrective actions plans to improve performance.

~~j.~~e. Quarterly reports of authorizations for non-network facilities

~~l.~~f. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying LTC Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.

DEFINITIONS / ACRONYMS

A. **Administrative Decisions a non-medical necessity denial decision made by** qualified non-clinical staff (example: Non-eligibility).

~~C.~~B. **Behavioral Healthcare Practitioner (BHP)** is a physician or other health professional who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse facility and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical arear of practice.

~~E.~~C. **Criteria** is systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.

~~F.~~D. **Denial** is a non-approval of a request for care or services based on either medical appropriateness or benefit coverage. This includes denials, partial approvals/modifications, and/or termination of existing care or service to the original

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request.

~~G.~~E. **Intermediate Care Facilities/Developmental Disability (ICF/DD)** are services provided in hospitals, skilled nursing facilities or intermediate care facilities for individuals with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center requiring skilled care or observation on an ongoing intermittent basis and 24-hour supervision.

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

i) Consistent with nationally accepted standards of medical practice:

(1) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer- reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

(2) For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.

(3) For purposes of covered services for Medi-Cal Members, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and

(4) When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable to

(a) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT

(b) Supplemental Services as defined in Title 22, 51340 and 51340.1.

~~I.~~G. **Medical Necessity Determination** is a UM decision that is based on predetermined criteria to be clinically appropriate for the member.

~~J.~~H. **Member** is any eligible beneficiary who is enrolled or ben assigned to with AAH.

~~K.~~I. **National Committee for Quality Assurance (NCQA**) is a non-profit organization

committed to evaluating and public reporting on the quality of health plans and other health care entities.

~~I.~~J. **Non-Contracted Provider** is a provider who is not contractually affiliated with AAH.

Pediatric Subacute Care Services are the health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.

K.

~~M.~~L. **Post Service or Retrospective** is an authorization request that occurs after a service or supply has been provided to a member.

~~O.~~M. **Prior Authorization**s an authorization request that occurs prior to services being rendered.

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

~~Q.~~O. **Qualified Health Care Professional** is a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.

~~R.~~P. **Subacute Facilities** provide a level of care needed by a member who does not need hospital acute care but who requires more intensive skilled nursing care than is provided to most patients in a SNF. Criteria for Subacute Services is in section 7.2 of the Medical Provider Manual. Subacute care patients are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care. Adult subacute care is a level of care that is defined as comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process.

~~S.~~Q. **Utilization Management (UM)** the process of evaluating and determining coverage and appropriateness of medically necessary services, by applying predefined criteria..

AFFECTED DEPARTMENTS/PARTIES

Long Term Care
Utilization Management
Grievance and Appeals Department
Claims Department
Case Management

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RELATED POLICIES AND PROCEDURES

1. LTC-001 Long Term Care
2. LTC-00~~43~~ Bed Hold and Leave of Absence
3. UM-054 Notice of Action
4. UM-057 Authorization Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

New Policy: 02/21/2023
Approved Updates: 3/19/2024,0 **4/16/2025, 5/20/2026, TBD**

Blue = material updates

REFERENCES

~~1. Department of Health Care Services (DHCS) and Alameda Alliance for Health Two Plan Model Contract~~
~~2. DHCS Single Plan Model Contract~~
~~3. Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services~~
~~4. Alliance Policy EE.1135: Long Term Care Facility Contracting~~
~~5.~~1. UM~~ Policy~~ 057 - Authorization and Processing of Referrals
~~6. G&A Policy – Grievance and Appeals~~
~~7. Claims Policy – Provider Disputes Resolution~~
~~8. The Alliance Provider Manual~~
~~9. The Alliance Utilization Management Program~~
~~10.~~2. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" ~~and~~ Templates~~Revised Notice Templates and Your Rights~~
~~11. DHCS All Plan Letter (APL) 22-032: Continuity of Care~~
~~12.~~3. DHCS ~~(APL)~~APL ~~24-009~~26-010 "Skilled Nursing Facilities - Long Term Care Benefit ~~Standardization and Transition of Members to~~Under Managed Care"
~~13. DHCS APL 24-011 Intermediate Care Facilities for Individuals with Developmental Disabilities-LTC Benefit Standardization and Transition of Members to Managed Care~~
4. DHCS APL 2~~4~~-01~~10~~ "Subacute Care Facilities - Long Term Care ~~Benefit Standardization and Transition of Members to~~ Benefit Under Managed Care"
5. DHCS APL 26-012 "Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefit Under Managed Care"
6. DHCS LTC Provider Manual
~~14.~~7. Medi-Cal Manual of Criteria, Chapter 7: Criteria for Long Term Care Services

~~16. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division~~

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~~17.~~8. Title 22, California Code of Regulations (CCR), §§ 51120, 51121, 51124, 51215, 51118 and 51212

~~18.~~9. Welfare and Institutions (W&I) Code, §§ 14087.55, 14087.6, 14087.9, and 14103.6

MONITORING

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1. Internal Monitoring
    a. The Long Term Care Department, on a routine basis, reviews:
        i. Results from the monthly authorization audits conducted by the Long Term Care leadership team. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
        iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
    b. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying LTC UM Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.
    c. The Internal Audit (IA) team conducts internal audits of the Alliance's Functional Areas in accordance with CMP-600 (Internal Audit). IA prioritizes audits based on assessed risk and leadership guidance.

POLICY AND PROCEDURE

Policy Number	LTC-004
Policy Name	LTC Bed Hold and Leave of Absence
Department Name	Long Term Care
Department Officer	Chief Medical Officer
Policy Owner	Director, Long Term Services and Supports
Line(s) of Business	MCAL, D-SNP
Effective Date	1/1/2023
Administrative Oversight Committee Approval Date	~~12/17/2025~~TBD

POLICY STATEMENT

The Alameda Alliance for Health (The Alliance/AAH) maintains current processes and guidelines for reviewing and approving Bed Holds and Leave of Absence (LOA) for M~~m~~embers residing in nursing facilities including Nursing Facility Level A (NF-A), Nursing Facility Level B (NF-B), Intermediate Care Facility for the Developmentally Disabled (ICF/DD), and Subacute Care Facilities.~~Long Term Care facilities.~~

AAH will provide continuity of care for Members that are transferred from a Skilled Nursing Facility (SNF) to a general acute care hospital and then require a return to a SNF level of care due to medical necessity.

A Bed hold ~~A Bed Hold occurs w~~is allowed, with appropriate physician orders, when a ~~hen a~~ Member residing in a nursing facility is admitted to an acute care hospital and ~~the Member is expected to~~ returns to the nursing facility at the same level of care ~~upon discharge from the acute hospital~~within 7 calendar days.. ~~AAH will provide continuity of care for Members that are transferred from a SNF to a general acute care hospital and then require a return to a SNF level of care due to medical necessity.~~

A Leave of Absence (LOA) is allowed, with appropriate physician orders and Regional Center approval, when a beneficiary leaves the facility to visit relatives or friends, or for participation by individuals with developmental disabilities in an organized summer camp for persons with developmental disabilities.

The AAH Bed Hold and LOA policy is compliant with State and Federal requirements noted in California Code of Regulations (CCR) Title 22, sections 72520, 51535, and 51535.1.

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PROCEDURE

A. Training for ~~Nursing~~ Facilities

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All facilities are trained on Bed Hold and LOA ~~Regulatory~~ requirements ~~-~~at the time of a new contract and ~~and~~ at least quarterly during Provider Office hours facilitated by the LTSS Liaison. The ~~annually. Training documents and The Facility Resource~~ Provider Manual also includes Bed Hold and LOA information, is ~~guide is~~ updated at least annually, and is ~~y and are available~~ accessible to all ~~SNFs~~ facilities ~~upon request~~ on demand by visiting the AAH website or Provider Portal.

B. ~~SNF Required~~ Communication with Member or Member's Authorized Representative

1. ~~SNFs~~ SNFs, Subacute Care Facilities, and ICF/DD Homes are required to n~~N~~otify the ~~all~~ Member~~s~~ or the Member's Authorized Representative in writing of their right to exercise the bed hold provision.
2. If a Member who has been hospitalized in an acute care hospital asserts their right to readmission under the law, but a SNF or Subacute Care Facility refuses to readmit them, the facility must notify the member of the refusal and provide information on how to appeal.
   ~~2.~~ The Member or Member's Authorized Representative has the right to appeal the facility's refusal under Health & Safety Code, section 1599.1(h)(1) and to request a ~~In the case that the SNF refuses to readmit the Member after an admission the SNF must notify the member of their right to request a~~ Refusal to Readmit (RTR) hearing.~~.~~
   a.
   b. Only the Member or Member's Authorized Representative may request the RTR hearing.
   ~~a.~~c. The RTR hearing request should be ~~is~~ submitted to the Office of Administrative Hearings and Appeals (OAHA) while the resident is still hospitalized.
   d. OAHA will conduct the RTR hearing only for those residents who wish to return to their nursing facility.

~~b.~~

~~c. Only a resident or the residents authorized representative may request RTR hearing.~~

C. Bed Hold Procedure

~~C.~~

~~1.~~ When a ~~beneficiary~~ Member residing in a SNF, Subacute Care Facility, or ICF/DD Home ~~nursing facility~~ is admitted to an acute care hospital, ~~-~~the ~~SN~~ facility must notify the AAH ~~UM~~ LTC/Inpatient UM department within 24 hours (1 business day) of the admission.

1.

2. ~~Upon~~ To get reimbursed for Bed Hold days while the member is admitted to an acute care hospital, the facility must notify the AAH LTC/Inpatient UM department of the requested Bed Hold dates using the Post Acute Authorization Form, and include the appropriate clinical documentation to support the Bed Hold request, including:
   a. A written physician order for the Bed Hold

b. A written physician order for the transfer to the acute care hospital

3. General Requirements for Reimbursement for Bed Hold days:
   a. The Bed Hold is limited to a maximum of seven days per hospitalization.
   b. The attending physician must order the acute hospitalization
   c. The Bed Hold is ordered by a licensed physician
   d. The day of departure is counted as one day of Bed Hold, and the day of return is counted as one day of inpatient care
   e. The Member's return from Bed Hold must not be followed by discharge within 24 hours
   f. The Bed Hold must terminate on a Member's date of death
   g. The facility must hold the bed vacant during Bed Hold when requested by the attending physician, unless the attending physician notifies the Skilled Nursing Facility (SNF) that the Member requires more than seven days of hospital care. Note: The facility cannot hold a bed after seven days. The facility claim must identify the inclusive dates of leave and claims submitted for Bed Hold for more than seven days will be denied.

4. AAH does not issue a separate authorization for a bed hold once an authorization for SNF, Subacute Care Facility, or ICF/DD Home is granted, provided the Member returns to the same facility at the same level of care following an acute hospital stay of seven days or less.

5. Upon receipt of the facility's notification of bed hold dates, the LTC/Inpatient UM department will review for the appropriate clinical documentation and adjust the dates within the existing authorization to reflect the bed hold dates. Facilities will receive updated notification letters within the appropriate turnaround times to delineate the bed hold days on the existing authorization. This will allow the bed hold days to be appropriately reimbursed when facilities submit claims.

~~a. notification to the acute hospital LTC UM will update the existing LTC authorization to show the bed hold revenue code.~~

~~a. Facilities should utilize the LTC authorization request form and/or discharge disposition form to notify AAH.~~

~~b. The IP UM team will process inpatient authorization for acute hospital admission.~~

~~2.~~6. ~~Facilities must bill for all bed hold (BH) days.~~If a Member remains hospitalized for greater than 7 days:

~~3. Reimbursement for bed hold days is subject to the following~~

~~a. The BH is limited to a maximum of seven days per hospitalization.~~

~~b. The attending physician must order the acute hospitalization (must have physicians order as part of documentation)~~

~~c. The facility must hold a bed vacant when requested by the attending physician, unless the attending physician notifies the Skilled Nursing Facility (SNF) that the Member requires more than seven days of hospital care at which time the Skilled Nursing Facility (SNF) will notify AAH.~~

   a. ~~LTC UM will close SNF authorization once BH is exhausted.~~The LTC department will close the existing SNF, Subacute Care, or ICF/DD authorization once Bed Hold days are exhausted.
   b. The Inpatient UM department will continue to review the inpatient admission

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concurrently until the Member is discharged to the next appropriate lower level of care.

c. The Inpatient UM department will ensure Member receives Transitional Care Services (TCS), including assignment of a single point of contact/care manager to assist Member throughout their transition. Referrals may be made to the AAH Case Management team or to Enhanced Care Management providers.

~~i.~~

~~ii. IP UM will continue to process all concurrent reviews until which time the Member is discharged to a SNF or Home~~

~~1. Member may be referred to Transitional Care Services to ensure smooth transitions between settings or to the community/home. This may be the LTC CM, the AAH CM, or other identified Care Manager.~~

~~iii. LTC UM will submit a referral for internal SW/DCP~~

~~1. LTC SW/DCP will work with the inpatient facility to address placement in another facility and may function as the assigned TCS Care Manager.~~

~~2. LTC SW/DCP will coordinate all community support services if member is discharged to home~~

D. ~~LOA~~ LOA Procedure - Nursing Facility

~~D.~~

1. When a Member residing in nursing facility is on LOA, the nursing facility must notify the AAH LTC/Inpatient UM department within 24 hours (1 business day) of the start date of the leave.

2. To get reimbursed for LOA days, the facility must notify the AAH LTC/Inpatient UM department of the requested LOA dates using the Post Acute Authorization Form, and include the appropriate clinical documentation to support the LOA request, including a written physician order for the LOA.

3. General Requirements for Reimbursement for LOA days:
   a. If the LOA is an overnight visit (or longer) to the home of relatives or friends, the time period is restricted as follows:
      i. Eighteen days per calendar year for non-developmentally disabled recipients.
      ii. Up to 12 additional days of leave per year may be approved in increments of no more than two consecutive days when the following conditions are met:
         a. The request for additional days of leave shall be in accordance with the individual recipient care plan and appropriate to the physical and mental well-being of the patient.
         b. At least five days of LTC inpatient care must be provided between each approved LOA.
         c. Seventy-three days per calendar year for developmentally disabled recipients.
         d. Thirty days for patients in a certified special treatment program for mentally ill recipients or recipients in a mental health therapy and rehabilitation program approved and certified by a local mental health director.
      iii. These limits are in addition to bed hold days ordered by the attending physician for each period of acute hospitalization for which the facility is reimbursed for reserving the Member's bed.
   b. The LOA is ordered by a licensed physician
   c. The day of departure is counted as one day of LOA, and the day of return is counted as

one day of inpatient care

d. The Member's return from LOA must not be followed by discharge within 24 hours
e. The LOA must terminate on a Member's date of death
f. The facility must hold the bed vacant during LOA.
g. Provisions for LOAs are part of the patient care plan for NF-A or NF-B.
h. Payment will not be made for the last day of leave if a recipient fails to return from leave within the authorized leave period.
i. A recipient's record maintained in the nursing facility must show the address of the intended leave destination and inclusive dates of leave. Note: The facility claim must identify the inclusive dates of leave.
j. For all NF-A and NF-B recipients, including the mentally disabled, the provider is paid the appropriate NF-A and NF-B rate(s), minus the raw food cost established by the Department of Health Care Services (DHCS) LOA days. The supplemental payment for special treatment programs for the mentally disordered is included in the LOA reimbursement.
k. If a Member has used the total number of leave days for the calendar year, the facility may still grant the recipient a LOA. However, the payment will not be made for any LOA days exceeding the maximum number of leave days allotted by these regulations per calendar year.
l. At the time of admission, if a Member has not been an inpatient in any LTC facility for the previous two months or longer, the recipient is eligible for the full complement of leave days as specified by these regulations

4. AAH does not issue a separate authorization for a LOA once an authorization for nursing facility is granted, provided there is a valid authorization covering the date the Member returns from the LOA.

5. Upon receipt of the facility's notification of LOA dates, the LTC/Inpatient UM department will review for the appropriate clinical documentation and adjust the dates within the existing authorization to reflect the LOA dates. Facilities will receive updated notification letters within the appropriate turnaround times to delineate the LOA days on the existing authorization. This will allow the LOA days to be appropriately reimbursed when facilities submit claims.

~~1. If the LOA is an overnight visit (or longer) to the home of relatives or friends, the time period is restricted as follows:~~
~~a) Eighteen days per calendar year for non-developmentally disabled recipients. Up to 12 additional days of leave per year may be approved in increments of no more than two consecutive days when the following conditions are met:~~
~~i. The request for additional days of leave shall be in accordance with the individual recipient care plan and appropriate to the physical and mental well-being of the patient.~~
~~ii. At least five days of LTC inpatient care must be provided between each approved LOA.~~
~~b) Seventy-three days per calendar year for developmentally disabled recipients.~~
~~c) Thirty days for patients in a certified special treatment program for mentally ill recipients or recipients in a mental health therapy and rehabilitation program approved and certified by a local mental health director.~~

~~*These limits are in addition to bed hold (BH) days ordered by the attending physician for each period of acute hospitalization for which the facility is reimbursed for reserving the~~

~~recipient's bed (bed hold).~~

~~2. LOA Requirements~~
~~a) Provisions for LOAs are part of the patient care plan for NF-A or NF-B.~~
~~b) Provisions for LOAs are part of the individual program plan for recipients in an ICF/DD, ICF/DD-H or ICF/DD-N facility.~~
~~c) Readmission Treatment Authorization Requests (TARs) are not necessary for recipients returning from a leave of absence if there is a valid TAR covering the return date.~~
~~d) Payment will not be made for the last day of leave if a recipient fails to return from leave within the authorized leave period.~~
~~e) A recipient's record maintained in an NF-A, NF-B, ICF/DD, ICF/DD-H or ICF/DD-N must show the address of the intended leave destination and inclusive dates of leave.~~
~~f) For all NF-A and NF-B recipients, including the mentally disabled, the provider is paid the appropriate NF-A and NF-B rate(s), minus the raw food cost established by the Department of Health Care Services (DHCS) LOA/BH days. The supplemental payment for special treatment programs for the mentally disordered is included in the LOA/BH reimbursement.~~
~~g) For all ICF/DD, ICF/DD-H or ICF/DD-N recipients, the provider is paid the appropriate ICF/DD, ICF/DD-H or ICF/DD-N rate(s) minus the raw food cost established by DHCS for LOA or bed hold days.~~
~~h) Payment will not be made for any LOA days exceeding the maximum number of leave days allotted by these regulations per calendar year.~~
~~i) At the time of admission, if a recipient has not been an inpatient in any LTC facility for the previous two months or longer, the recipient is eligible for the full complement of leave days as specified by these regulations~~

~~3. AAH LTC-UM Process for LOA~~
~~a) When a beneficiary residing in a nursing facility is on LOA the Nursing facility must notify AAH UM within 24 hours (1 business day).~~
~~b) Upon notification LTC-UM will update open LTC authorization with the LOA revenue code~~
~~c) Upon return form LOA the Nursing facility will notify AAH LTC-UM and LTC-UM will update open LTC authorization with the appropriate revenue code (SN or CC)~~

~~*If a recipient has used the total number of leave days for the calendar year, the facility may grant the recipient a leave of absence. However, the facility will not receive reimbursement for those unauthorized leave days from AAH.~~

E. ~~Developmentally Disabled (DD)~~ LOA Procedure – ICF/DD Home
~~E.~~

1. When a Member residing in a ICF/DD Home is on LOA, the ICF/DD home must notify the AAH LTC department within 24 hours (1 business day) of the start date of the leave.

2. To get reimbursed for LOA days, the ICF/DD must notify the AAH LTC department of the requested LOA dates using the Post Acute Authorization Form, and include the appropriate clinical documentation to support the LOA request, including a written physician order for

the LOA if the Member is participating in a summer camp for the developmentally disabled.

3. General Requirements for Reimbursement for LOA days for Members with Developmental Disabilities:
   a. Members with developmental disabilities can receive a LOA for relatives/friend visits or summer camp for up to 73 days per calendar year, per CCR, Title 22, Section 51535
   b. If an overnight LOA is for summer camp participation, the Member's attendance must be prescribed by a licensed physician and approved by the appropriate Regional Center
   c. These limits are in addition to bed hold days ordered by the attending physician for each period of acute hospitalization for which the facility is reimbursed for reserving the Member's bed.
   d. The day of departure is counted as one day of LOA, and the day of return is counted as one day of inpatient care
   e. The Member's return from LOA must not be followed by discharge within 24 hours
   f. The Member is not discharged from the facility while attending camp
   g. Term of absence at camp plus any other accumulated leave days for the calendar year (not including acute care stays) do not exceed 73 days per calendar year
   h. If the recipient expires while at camp, the LOA terminates on the day of death (discharge date is the day of the death)
   i. If a recipient is admitted to an acute care hospital from camp, the LOA terminates on the day of departure from camp.
   j. If a recipient leaves camp and does not return to the ICF/DD Home, the LOA terminates on the day of departure.
   k. The facility must hold the bed vacant during LOA.
   l. Provisions for LOAs are part of the individual program plan for recipients in an ICF/DD.
   m. Payment will not be made for the last day of leave if a recipient fails to return from leave within the authorized leave period.
   n. A recipient's record maintained in the nursing facility must show the address of the intended leave destination and inclusive dates of leave. Note: The facility claim must identify the inclusive dates of leave.
   o. For all ICF/DD recipients, the provider is paid the appropriate ICF/DD rate(s) minus the raw food cost established by DHCS for LOA days.
   p. If a Member has used the total number of leave days for the calendar year, the facility may still grant the recipient a LOA. However, the payment will not be made for any LOA days exceeding the maximum number of leave days allotted by these regulations per calendar year.
   q. At the time of admission, if a Member has not been an inpatient in any LTC facility for the previous two months or longer, the recipient is eligible for the full complement of leave days as specified by these regulations

4. AAH does not issue a separate authorization for a LOA once an authorization for ICF/DD is granted, provided there is a valid authorization covering the date the Member returns from the LOA.

5. Upon receipt of the ICF/DD Home's notification of LOA dates, the LTC department will review for the appropriate clinical documentation and adjust the dates within the existing authorization to reflect the LOA dates. ICF/DD Homes will receive updated notification

letters within the appropriate turnaround times to delineate the LOA days on the existing authorization. This will allow the LOA days to be appropriately reimbursed when ICF/DD Homes submit claims.

~~1. Developmentally disabled (DD) recipients can receive a leave of absence (LOA) for relatives/friend visits or summer camp for up to 73 days per calendar year.~~
~~2. If an overnight LOA is for summer camp participation by a DD recipient, a physician signature is required.~~
~~3. Skilled nursing and intermediary care facilities will receive reimbursement for DD recipients attending relatives/friend visits or summer camp for up to 73 days per calendar year if the following qualifications are met.~~
~~a) Recipient's attendance at camp is prescribed by a licensed physician and approved by an appropriate regional center for the developmentally disabled.~~
~~b) Recipient is not discharged from the facility while attending camp.~~
~~c) Facility holds a recipient's bed during the period of absence.~~
~~d) Term of absence at camp plus any other accumulated leave days for the calendar year (not including acute care stays) do not exceed 73 days per calendar year~~
~~4. AAH LTC UM Process for LOA~~
~~a) When a beneficiary residing in a nursing facility is on LOA the SN facility must notify AAH UM within 24 hours (1 business day).~~
~~b) Upon notification LTC UM will update open LTC authorization with new skill level and enter LOA revenue code~~
~~c) Upon return form LOA the SN facility will notify AAH LTC UM and LTC UM will update open LTC authorization with new skill level and enter appropriate revenue code (SN or CC)~~

~~**F. Leave of Absence Termination**~~
~~1. The LOA will terminate, and the discharge status will take effect under the following circumstances:~~
~~a) If the recipient expires while at camp, the LOA terminates on the day of death (discharge date is the day of the death).~~
~~b) If a recipient is admitted to an acute care hospital from camp, the LOA terminates on the day of departure from camp.~~
~~c) If a recipient leaves camp and does not return to the nursing facility, the LOA terminates on the day of departure.~~

~~**G.** General Requirements for Bed Hold and LOA~~
~~1. The day of departure is counted as one day or LOA/BH, and the day of return is counted as one day of inpatient care.~~
~~2. A facility will hold the bed vacant during LOA/BH.~~
~~3. A LOA or BH is ordered by a licensed physician.~~
~~4. A recipient's return from LOA/BH must not be followed by discharge within 24 hours.~~
~~5. A LOA/BH must terminate on a recipient's date of death.~~
~~6. A facility claim must identify the inclusive dates of leave.~~

DEFINITIONS / ACRONYMS

A. **Acute Care Hospital** means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services.

B. **Authorization Status** evaluation of whether care is medically necessary and otherwise covered

C. **Bed Hold** is a temporary reimbursable status that allows one to return to a nursing facility after an acute care hospitalization

~~D. **Community Support Services** includes support that may be organized through extended family members, friends, neighbors, religious organizations, community programs, cultural and ethnic organizations, or other support groups or organizations~~

~~E.~~D. **Concurrent Review** is a review of medical necessity decisions made while the patient is currently in an acute or post-acute setting

~~F.~~E. **Discharge Planner** is one who identifies and prepares for a patient's anticipated health care needs after they leave the hospital

~~G.~~F. **LTC** refers to Long Term Care

~~H.~~G. **Member** means any eligible beneficiary who has enrolled in AAH and who has been assigned to or selected a Plan.

~~I.~~H. **OAHA is the Office of Administrative Hearings and Appeals** ~~-~~ ~~is~~ an administrative hearing forum created by the Department of Health Care Services to provide a fair and impartial appeal process for providers and individuals.

~~J.~~ **RTR** ~~Appeals~~ **is Refusal to Readmit** ~~-:~~ under federal and state law, when a resident is transferred to the hospital or approved for therapeutic leave, they have a right to return to the nursing facility after they are hospitalized or when the period of therapeutic leave has concluded. When the resident is hospitalized and the nursing facility refuses to readmit the resident, the resident may request a RTR hearing.

I.

~~K.~~J. **Skilled Nursing Facility (SNF)** is a health facility that provides skilled nursing and supportive care to persons who need this type of care on an extended basis.

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

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use of resources.

~~L.~~

AFFECTED DEPARTMENTS/PARTIES

Long Term Care
Utilization Management (Inpatient)
~~Long Term Care~~
~~Case Management~~
Claims
Case Management
~~Billing~~

RELATED POLICIES AND PROCEDURES

LTC-001 – Long Term Care Program
LTC-002 - Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
LTC-003 – LTC Case Management Identification and Enrollment
CM-034 -Transitional Care Services
UM-001 – Utilization Management
UM-057 – Authorization Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

New Policy: 2/23/2023

Updates: **3/19/2024**, **6/12/2024**, **12/17/2025**, **TBD**

Blue = material updates

REFERENCES

CA Code of Regulations Title 22, Sections 51335, 51535.1, 51335.5, 51335.6, 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6, and 51334

DHCS APL ~~24-009~~26-010 "Skilled Nursing Facilities - Long Term Care Benefit ~~Standardization, and Transition of Members to~~Under Managed Care"

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DHCS APL 26-011 "Subacute Care Facilities - Long Term Care Benefit Under Managed Care"

DHCS APL ~~24-011~~26-012 "Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit ~~Standardization, and Transition of Members to~~Under Managed Care"

~~DHCS APL 24-010 "Intermediate Care Facilities Long Term Care Benefit Standardization, and Transition of Members to Managed Care"~~

DHCS ~~Policy~~ LTC Provider Manual, ~~on~~ Leave of Absence, Bed Hold, and Room and Board~~, dated August 2020~~

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to QIHE/UMC~~C~~ (Quality Improvement Health Equity/Utilization Management ~~C~~Committee) annually.

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POLICY AND PROCEDURE

Policy Number	CLS-001
Policy Name	Cultural and Linguistic Program Description
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	1/1/2007
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

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

The Alliance Population Needs Assessment (PNA) plays an important role in informing the Alliance Cultural and Linguistic Services Program. The PNA offers a comprehensive look at the member health needs and disparities, identifies gaps in services, and defines targeted strategies to address those gaps. The Alliance CLS Program is reviewed and updated regularly to align with the PNA. See *PH-005 Population Assessment* for additional details.

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

PROCEDURE

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

DEFINITIONS / ACRONYMS

CCR: California Code of Regulations
CFR: Code of Federal Regulations
CLAS: Culturally and Linguistically Appropriate Services
CLS: Cultural and Linguistic Services
DHCS: Department of Health Care Services
D-SNP: Dual Eligible Special Needs Plan
PNA: Population Needs Assessment

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Provider Network

RELATED POLICIES AND PROCEDURES

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

REVISION APPROVAL HISTORY

1/1/07, 1/1/08, 9/2009, 2/26/2010, 4/13/15, 3/24/2016, 11/10/2016, 5/25/2017, 5/3/2018, 5/16/2019, 3/19/2020, 3/18/2021, 3/22/2022, 3/21/2023, 03/19/2024, 4/16/2025, 11/19/2025, TBD

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Alameda Alliance for Health Cultural and Linguistic Services Program Description

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REFERENCES

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

MONITORING

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

POLICY AND PROCEDURE

Policy Number	CLS-002
Policy Name	Community Engagement
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	4/1/1999
Administrative Oversight Committee Approval Date	~~9/19/2025~~TBD

POLICY STATEMENT

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

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

PROCEDURE

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

1.3. As the Alliance creates new initiatives or process updates, project leaders consider whether member and family feedback will be needed, what would be the best format, and how to incorporate the feedback into updated policies and decision-making.
1.4. Members who participate in the process will be informed of the impact of their feedback through community meetings or other forms of communication.
1.5. The Alliance maintains documentation of member feedback and results in order to ensure accountability for incorporating members and family input into policies and decision-making.
1.6. Member engagement and input is incorporated into the Quality Improvement and Health Equity Program Evaluation to measure and monitor the impact of the input. (*QI-101 Quality Improvement Program*)
1.7. The Alliance conducts member surveys and incorporates the results in quality improvement and health equity activities. (*QI-117 Member Satisfaction Survey)*
1.8. The Alliance has a Community Advisory Committee (CAC) that meets regularly to provide diverse members and family input into Alliance policies, procedures, and programs. The findings and recommendations inform Alliance activities and interventions.
1.9. The CAC is comprised primarily of Alliance members, as part of the Alliance's implementation and maintenance of member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.
1.10. The Alliance partners with community-based organizations to cultivate member and family engagement.
1.11. The CAC's input is actively utilized in policies and decision-making.

2. Community Advisory Committee Membership
2.1. The Alliance convenes a selection committee tasked with selecting the members of the CAC. The CAC Selection Committee reports to the Alliance Board of Governors (BOG). The Alliance makes a good faith effort to ensure that the Alliance CAC Selection Committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC.
2.1.1. Alliance BOG representatives including Safety Net Providers, Federally Qualified Health Centers (FQHCs), behavioral health, regional centers, local education authorities, dental Providers, Indian Health Service (IHS) Facilities, and home and community-based Providers.
2.1.2. Persons and community-based organizations who represent the diversity of Alameda County.
2.2. The membership of this committee reflects the general demographics and characteristics of the Medi-Cal and D-SNP members in the county. Including the following or their representatives:
2.2.1. Representatives from any Indian Health Service providers
2.2.2. Adolescents and/or parents and/or caregivers of children, including foster

youth.

2.2.3. D-SNP members

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

2.3.1. Populations who experience health disparities

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

2.3.3. Persons with chronic conditions

2.3.4. Limited English Proficient (LEP) Members

2.4. The CAC is comprised of the following members:

2.4.1. At least 51% of the CAC are Alliance enrollees (and/or the parents/caregivers of Alliance enrollees who are minors or dependents).

2.4.2. At least one CAC member shall be a provider

2.4.3. The CAC may also include community advocates for hard-to-reach member populations.

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

2.6. Should a CAC member resign, is asked to resign, or is otherwise unable to serve on the CAC, the Alliance will make its best effort to promptly replace the vacant seat within 60 calendar days of the CAC vacancy, including holding a CAC Selection Committee meeting, where Selection Committee members will vote and select new members.

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

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

3. CAC Coordinator

3.1. The Alliance designates the Cultural and Linguistic Services Specialist as the CAC Coordinator and maintains a detailed job description detailing the CAC Coordinator's responsibility to manage the operations of the CAC in compliance with all the statutory, rule, and contract requirements including but not limited to:

3.1.1. Scheduling meetings and creating agendas with the input of CAC members.

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

3.1.3. Actively facilitating communications and connections between the CAC and Alliance leadership, including ensuring CAC members are informed of Alliance

decisions relevant to the work of the CAC.

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

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

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

4. CAC Terms of Service and Attendance:

4.1. The term of service for each CAC member is two (2) years.

4.2. Committee members may serve more than one term, at the discretion of the CAC Selection Committee.

4.3. The CAC Selection Committee~~A member~~ may ~~be dismissed~~dismiss a member from the ~~committee~~ CAC if ~~he or she fails to~~they do not attend at minimum two (2) quarterly meetings of the committee within one (1) year. ~~without an excused or approved absence.~~

4.4. Members must notify the Alliance of expected absences.

~~4.5. Members can request a leave of absence if needed for up to one (1) year for health or personal reasons.~~

~~4.6.~~4.5. Plan members receive ~~compensation or~~ a stipend for each meeting attended to cover time and participation, including participation in the CAC, the Alliance Board of Governors and participation in the DHCS' Statewide Community Advisory Committee. Stipends for in-person meetings cover transportation costs for members. Members may also request and receive reimbursement for childcare.

~~4.7.~~4.6. Members who cannot use regular transit because of a disability or disabling health conditions may request assistance from the Alliance to arrange for services from East Bay Paratransit.

5. CAC Meetings:

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

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

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

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

6. Alliance CAC Support
   6.1. The Alliance will provide the following to the CAC:
      6.1.1. Educate CAC members to ensure they can effectively participate in CAC meetings.
      6.1.2. Support to address barriers to participation of CAC members, including childcare, transportation, flexible meeting times and formats so the highest CAC member participation is possible, convenient location, and format.
      6.1.3. Sufficient resources, within budgetary limitations, to support CAC activities, member outreach, retention, and support, as well as consumer listening sessions, focus groups, and/or surveys.
      6.1.4. The Alliance will provide a feedback loop to inform CAC members how their input has been incorporated into relevant policies and procedures.
   6.2. The Alliance ~~Chief~~ Health Equity Officer participates as a non-voting member of the CAC and supports the work of the CAC through consultation and reports as needed.

7. Duties of the CAC
   7.1. Participate in establishing the public policy of the plan as described in Title 28, California Code of Regulations 1300.69(b).
   7.2. Provide input into annual reviews and updates to relevant policies and procedures, and particularly those affecting quality improvement and health equity.
      7.2.1. CAC feedback is incorporated into the Cultural and Linguistic Services Program, the Population Heath Management Strategy and the Quality Improvement and Health Equity Program.
   7.3. Identify and advocate for preventive care practices to be ~~utilized~~ used by the Alliance.
   7.4. Provide input into developing and updating cultural and linguistic policy and procedure decisions including those related to ~~quality improvement, education, and operational and~~ cultural competency issues, educational and operational issues affecting seniors, ~~groups~~people who speak a primary language other than English, and people who have disability.
   ~~7.4.~~7.5. ~~This may include advising~~Advise on ~~necessary~~ Alliance ~~M~~member and~~or~~ p~~P~~rovider~~-~~-targeted services, programs, and trainings.
   7.6. Provide and make recommendations regarding cultural appropriateness of communications, partnerships, and services.
   ~~7.5.~~7.7. Provide recommendations and feedback on the diversity, equity, and inclusion training program.
   7.8. Inform and validate the development of the Alliance's Community Reinvestment Plans.
   ~~7.6.~~7.9. Provide input, advice, and making recommendations to address Quality of Care, Health Equity, Health Disparities, ~~Review~~ Population ~~Needs Assessment~~

~~(PNA)~~Health Management (PHM), children services, the Community Health Assessments/Community Health Improvement Plans (CHAs/CHIPs), including how to use findings from the CHAs/CHIPs to influence Alliance strategies and workstreams related to the Department of Healthcare Services Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs. ~~findings and discuss opportunities with an emphasis on Health Equity and Social Drivers of Health, and providing input in the selection of health education, cultural and linguistic and quality improvement strategies.~~

~~7.7.~~7.10. Provide input and advice, including, but not limited to, the following:

~~7.7.1.~~7.10.1. Culturally appropriate service or program design

~~7.7.2. The Alliance's diversity, equity, and inclusion strategy~~

~~7.7.3.~~7.10.2. Priorities for health education and outreach programs

~~7.7.4.~~7.10.3. Member satisfaction survey results

~~7.7.5. Findings of the PNA~~

~~7.7.6.~~7.10.4. Plan marketing materials and campaigns

~~7.7.7.~~7.10.5. Communication of needs for Network development and assessment

~~7.7.8.~~7.10.6. Community resources and information

~~7.7.9.~~7.10.7. ~~Population health management and health equity~~ PHM

~~7.7.10.~~7.10.8. Quality, ~~Improvement,~~ including:

~~7.7.10.1.~~7.10.8.1. Member satisfaction survey results pertinent to timely access standards

~~7.7.10.2.~~7.10.8.2. Quality improvement activities and interactions

~~7.7.11. Health Delivery Systems Reforms to improve health outcomes~~

7.10.9. Carved Out Services

7.10.10. Development of the covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan.

~~7.7.12.~~7.10.11. Input on Quality Improvement and Health Equity and the Population Needs Assessment

~~7.7.13.~~7.10.12. ~~Coordination of Care~~Reforms to improve health outcomes, accessibility of services, and coordination of care for Members

~~7.7.14. Health Equity~~

~~7.7.15.~~7.10.13. ~~Accessibility of Services~~Inform the development of the provider manual

~~7.7.16.1.1.1. Development of the covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan.~~

8. Annual CAC Demographic Report
   8.1. The Alliance will submit an annual demographic report regarding the CAC on April 1st of each year using the DHCS CAC Annual Demographic Report template with descriptions of the following.
      8.1.1. The demographic composition of CAC membership
      8.1.2. How Alliance defines the demographics and diversity of its Members and

Potential Members within Alliance's Service Area

8.1.3. The data sources relied upon by the Alliance to validate that its CAC membership aligns with the Alliance's Member demographics

8.1.4. Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within Contractor's Service Area

8.1.5. Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Alliance's Service Area.

8.1.6. A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Alliance's initiatives and/or policies.

9. Reporting structure for the CAC

9.1. The CAC's activities and feedback are reported to the Cultural and Linguistic Services Subcommittee, and other subcommittees as requested, which report to the Quality Improvement ~~and~~ Health Equity/Utilization Management Committee (QIHE/UMC), a subcommittee of the Alliance Board of Governors.

DEFINITIONS / ACRONYMS

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

PNA: Population Needs Assessment

AFFECTED DEPARTMENTS/PARTIES

All

REVISION APPROVAL HISTORY

4/1/1999, 1/1/08, 9/1/09, 2/26/10, 3/11/10, 2/5/2015, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 3/22/2022, 3/21/2023, **12/19/2023**, **03/19/2024**, **4/16/2025, 9/19/2025, TBD**

Blue = material updates

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REFERENCES

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

MONITORING

This policy will be reviewed annually to ensure effectiveness.

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

POLICY AND PROCEDURE

Policy Number	CLS-003
Policy Name	Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	7/01/1998
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

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

PROCEDURE

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

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

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

after- hours interpreter services, the provider can call the Alliance interpreter service vendor directly to receive telephonic interpreter services.

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

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

3. The Alliance coordinates interpreter services at the time of appointment scheduling. Members needing interpreter services for a future health care appointment:
   3.1. May call Alliance Member Services to request assistance with arranging for an interpreter for their future appointment.
      3.1.1. If the request is at least 5 business days advanced notice, the Alliance Member Services contacts the provider and asks them to submit an *Interpreter Services Request Form* to the Alliance to request an interpreter or use Alliance's 24/7 telephonic interpreter services. In-person requests must meet current guidelines.
      3.1.2. If less than 5 business days-notice, Alliance Member Services staff contacts provider and provides education on accessing telephonic interpretation through Alliance interpreter services vendor, or as last resort, reschedules the appointment.
   3.2. May call the provider to request an interpreter for their appointment. Providers will offer interpreter services to members with non-English language preferences. These services may be provided by:
      3.2.1. A qualified bilingual staff or interpreter at the health care provider office
      3.2.2. The Alliance 24/7 telephonic interpreter service
      3.2.3. Providers can fax a request to the Alliance to schedule in-person or prescheduled telephonic/video interpreters.
   3.3. In-person interpreters are available for American Sign Language (ASL), complex, highly sensitive visits, or other circumstances upon approval by Alliance.
   3.4. When interpreter requests for in-person interpretation are made with less than 5 business days' notice, the provider or member may be asked to use a telephonic interpreter for the appointment (except for ASL interpreters) or reschedule only if no in-person interpreter can be arranged.
   3.5. ASL interpreter requests cannot be arranged with a telephonic interpreter. When an ASL interpreter cannot be arranged in advance or offered through video remote interpreting, providers may use the California Relay Service (CRS) to contact deaf or hard of hearing members by phone, if other services are not available in the office.

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

5. The Alliance assures timely delivery of language assistance services through performance monitoring of interpreter services coordination, provision of telephone and video interpreting

(where available) and scheduling in-person interpreter services for future appointments. See *CLS -011 Compliance Monitoring of C & L Program* for details.

6. The Alliance ensures that individuals who provide language interpretation services for Alliance members are qualified.
   6.1. Qualified interpreters:
      6.1.1. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language (qualified interpreters for relay interpretation must demonstrate proficiency in two non-English spoken languages);
      6.1.2. Be able to interpret effectively, accurately, and impartially to and from such language and English (or between two non-English languages for relay interpretation), using any necessary specialized vocabulary or terms without changes, omissions, or additions and while preserving the tone, sentiment and emotional level of original orate statement;,
      6.1.3. Adhere to generally accepted interpreter ethic principles, including client confidentiality.
   6.2. These standards are included in the vendor contracting language.
   6.3. See *CLS-010 CLS Staff Training* for additional details on Alliance bilingual staff assessment.
   6.4. See *CLS-009 CLS Program - Contracted Providers* for details on documenting qualifications of bilingual providers.
   6.5. See *CLS-011 CLS Program Compliance Monitoring* for details on how the Alliance monitors interpreter quality.

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

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

and the written non-English language(s) in need of translation

8.3. Can translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology

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

8.4.1. Member Handbook (Evidence of Coverage)
8.4.2. Provider Directory
8.4.3. new member welcome packets
8.4.4. marketing information
8.4.5. member rights information
8.4.6. form letters and individual notices including notice of action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and other letters containing important information regarding eligibility and participation criteria
8.4.7. applications, consent forms,
8.4.8. notices advising LEP members of the availability of at no cost language assistance, and
8.4.9. documents that require a response by the member
8.4.10. and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 25-005

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

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

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

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

8.6.3. When Members request to receive translated written information in either traditional or simplified Chinese characters, the Alliance provides information in the Member's preferred characters. Otherwise, the Alliance has a process to translate written information in Traditional Chinese characters.

8.7. Member Services staff are also available to assist non-English speaking members in understanding information in Alliance documents. Bilingual/multilingual staff will read relevant documents to the member, staff will use our interpreter service to interpret the

document, or staff will request a translation of the document for the member.

9. **Community Services Program Referrals.** The Alliance maintains referral lists of culturally and linguistically appropriate community services programs. Members are informed of available programs through contact with the Member Services, and Health Care Services Departments, the Alliance website (alamedaallianc.org) and member newsletters. Providers are informed of available programs at least annually through provider visits and through the Alliance provider website.

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

Alliance Case Management who will offer health navigation support to receive the auxiliary aids and services needed. See Alliance policy UM-045 Communications Services for more information.

11. **Quality of Interpreter Services for Members with Disabilities**. When providing interpreting services to members with disabilities, the interpreter must meet the qualifications described previously in this document. Qualified interpreters may include ASL interpreters, oral transliterators, or cued language transliterators. Any interpreter for members with disabilities provided through VRI must have high quality images with display able to accommodate the interpreter's and participating individual's face, arms, hands and fingers, and meet VRI requirements described previously in this document.
    11.1. As with other language interpreters, the Alliance does not require members with disabilities to bring their own interpreter and does not rely on adult or minor children to accompany an individual except as listed below.

12. **Informing Members.** The Alliance informs members, including members with disabilities, and providers of the availability of language services at no cost, including interpreters for LEP members, ASL interpreters, written translation, availability of alternative formats, auxiliary aids and services, and access for the deaf or hard of hearing through multiple methods.
    12.1. The Alliance does not rely on the use of the member's family, friends, or unqualified staff as interpreters.
        12.1.1. Providers are educated on the risks of using unqualified interpreters.
        12.1.2. Adult or minor children should not interpret except in cases of emergency where there is imminent threat to the safety and welfare of the person, or the public, and a qualified interpreter is not available or the LEP member specifically requests that an accompanying adult interprets, the adult agrees to assist and relying on that adult is appropriate under the circumstances.
        12.1.3. Providers must inform members of their right to qualified interpreter services and document the refusal in the patient's medical record.
    12.2. Members are informed of their right to language services at no cost, alternative formats and auxiliary aids in the New Member Welcome packet, the Member Handbook, the Alliance member website, member newsletters, non-discrimination notice and language assistance Notice of Availability (previously "taglines") sent out with member informing communications and when communicating with Alliance staff.
    12.3. Providers are informed of how to access the plan's language services at no cost and are educated on how to use interpreter services, alternative formats, and auxiliary aids and services through the New Provider Orientation, provider site visits, Alliance provider website and the Provider Manual.

13. Nondiscrimination Notice.

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

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

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

13.4. The notice is also posted in at least 20-point san serif font in conspicuous physical locations where the Alliance interacts with the public, as well as on the Alliance website in an easily found location.

13.5. The Alliance does not replace printed nondiscrimination notices or Notice of Availability by the use of quick response codes (QR codes).The nondiscrimination notice includes all legally required elements as well as information on how to file discrimination grievances with DHCS Office of Civil Rights (OCR), and with the plan, as is described in the DHCS nondiscrimination notice template.

13.6. The Alliance uses an abbreviated nondiscrimination statement for small-sized information notices (i.e., postcards, pamphlets, newsletters, brochures, and flyers that are printed and/or distributed on paper or folded in a way that is smaller than 8.5 X 11 inches). The abbreviated nondiscrimination statement is accompanied by the full set of language taglines in 18 non-English languages.

14. Discrimination Grievances. Discrimination Grievance is defined in the Definitions section of this policy.

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

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

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

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

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

15.1. The Alliance provides the Notice of Availability in at least 12-point sans serif font in English and the top 18-non-English languages.

15.2. Current languages in the Notice of Availability include the top 18 non-English languages spoken by LEP individuals in California, as identified by HHS OCR in 2016, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese as well as Laotian, Ukrainian and Mien which are used in Medi-Cal Fee for Service (FFS).

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

15.3.1. The Notice of Availability is provided upon request, included in the Member Handbook/EOC and other electronic and written communications, posted in clear and prominent physical locations where the Alliance interacts with the public in at least 20-point sans serif font, on the Alliance website, and in all member information and other informational notices.

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

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

16.2. Using qualified translators for written translation.

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

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

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

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

16.7. Members with disabilities and their Authorized Representatives (AOR) can request care coordination from Alliance Case Management. See *UM-002 Coordination of Care* and *CM-029 Developmental Disabilities.*

DEFINITIONS / ACRONYMS

ACA: Affordable Care Act

Alternative Format Selection (AFS): Formats such as Braille, audio format, large print (no less

than 20-point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary
aids and services that may be appropriate.
ASL: American Sign Language
Auxiliary Aids: Devices used by persons with disabilities for communication, such as Telephone Typewriters (TTY) or Telecommunication Devices for the Deaf (TDD).
CLS: Cultural and Linguistic Services
CRS: California Relay Services
Cued language transliterators: Individuals who represent or spell by using a small number of handshapes.
Discrimination Grievance: Any complaint or grievance alleging discrimination prohibited by applicable federal or state civil rights or nondiscrimination laws, including, but not limited to, Title VI of the Civil Rights Act, Title IX of the Education Amendments, the Age Discrimination Act, the Americans with Disabilities Act (ADA), Sections 504 and 508 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, California Government Code section 11135, and the Unruh Civil Rights Act.
D-SNP: Dual Eligible Special Needs Plan
FFS: Fee for Service
Interpreter: An interpreter is a person who renders a message spoken in one language into one or more languages.
Interpretation services include: (1) availability of trained bilingual/multilingual plan and provider staff (2) hiring staff interpreters (3) contracting with an outside interpreter service for qualified interpreters (4) arranging for the services of voluntary, qualified community interpreters (5) contracting for telephone, videoconferencing, or other telecommunication supported interpretation services.
LEP: Limited English Proficient
OCR: Office of Civil Rights
Oral transliterators: Individuals who represent or spell in characters of another alphabet.
TDD: Telecommunications Devices for Deaf
Translation – Translation is the replacement of written text from one language into another.
TTY: -(Teletypewriter) is a communication device used by people who are deaf, hard-of-hearing, or have severe speech impairment.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Provider Network

REVISION APPROVAL HISTORY

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

03/19/2024, 4/16/2025, 11/19/2025, TBD

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RELATED POLICIES AND PROCEDURES

CLS-008	Member Assessment of Cultural and Linguistic Needs
CLS-009	CLS Program - Contracted Providers
CLS-010	CLS Program - Staff Training
CLS-011	CLS Program Compliance Monitoring
CM-029	Developmental Disabilities
C&O-001	Community Relations and Outreach Activities
QI-105	Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Survey (PARS)
UM-002	Coordination of Care
UM-045	Communications Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

Americans with Disabilities Act of 1990
CFR, Part 42 Sections 438.10(d), 439.10, 438.404 and 438.408
DHCS All Plan Letter 25-005
DHCS All Plan Letter ~~22-002~~25-016
DHCS Exhibit A, contract Attachments 9, Sections 13 and 14
Government Code Sections 11135 and 7405
2024 DHCS Exhibit A Attachment III Section 5.2.10 Access Rights
Patient Protection and Affordable Care Act, Section 1557
Title VI, Civil Rights Act of 1964
Title 22, CCR, Sections 51202.5 and 51309.5(a), 53853(c), 53876, and 53884
Title 28, CCR sections 1300.67.04(c)(2)(A)-(B) and 1300.67.04 (c) (2)(G)(v) – (c) (4)
Rehabilitation Act of 1973, Sections 504 and 508
SB 223 Health Care Language Assistance Services
SB 1423 Oral Interpretation Services
W&I Code 14029.91
Centers for Medicare and Medicaid Services (CMS)

MONITORING

This policy will be reviewed annually to ensure effectiveness.

POLICY AND PROCEDURE

Policy Number	CLS-008
Policy Name	Member Assessment of Cultural and Linguistic Needs
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	4/13/2015
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Health and Alameda Alliance Wellness (D-SNP) complies with all contractual and regulatory requirements pertaining to the assessment of enrollees to offer its members culturally and linguistically appropriate services. Results of the assessments are used to determine threshold languages and translation of member informing materials for members. The Alliance's cultural and linguistic assessments comply with Title 22, CCR, Section 53858(e)(6); Title 28, CCR, Section 1300.68(b)(3); the Department of Health Care Services (DHCS) APL 17-006, Title 42, Code of Federal Regulations, and Centers for Medicare and Medicaid Services (CMS)

PROCEDURE

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

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

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

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

4. The Alliance translates, using a qualified translator, member informing materials into languages that meet the following criteria:
   4.1. A population group of eligible beneficiaries residing in the Alliance's service area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000 or five-percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and
   4.2. A population group of eligible beneficiaries residing in the Alliance's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes (Concentration Standard Language).
   4.3. The Alliance distributes written notice, a Notice of Availability, in English and up to 15 languages. The Notice informs members that the Alliance provides free language assistance services and how to obtain the services.
      4.3.1. The up to 15 languages include DHCS defined in APL 25-001 and languages spoken by 1% of individuals or by 200 individuals, whichever is less, who are served by the organization.
      4.3.2. See *CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities* for policies and procedures regarding distribution of the Notice of Availability.
   4.4. All Alliance departments communicating with members are responsible for ensuring their staff translate or interpret all member informing materials. The Alliance's Communications and Outreach Department has the responsibility of providing translations using qualified translators of those materials as needed. See *CLS-003 Language Assistance Services* and *C&O-001 Community Relations and Outreach Activitie*s for policies and procedures regarding document translation.

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

6. The Alliance informs LEP members of language services at no cost through the following strategies (For more details on these notices and strategies for informing members about language services, see *CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities.*):
   6.1. Member ID card letter
   6.2. Alliance provider and member websites

6.3. Plan member newsletter
6.4. Plan letters connecting members to plan services including Health Education and Case Management
6.5. Notice of non-discrimination, language assistance and effective communication for individuals with disabilities and taglines offering free language assistance services

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

DEFINITIONS / ACRONYMS

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

AFFECTED DEPARTMENTS/PARTIES

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

REVISION APPROVAL HISTORY

Replaced MED-CLS-006 Language Identification 11/20/2008
Updates: 4/13/2025, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, **3/19/2024**, 4/16/2025, **11/19/2025, TBD**

Blue = material updates

RELATED POLICIES AND PROCEDURES

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

REFERENCES

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

MONITORING

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

POLICY AND PROCEDURE

Policy Number	CLS-009
Policy Name	Cultural and Linguistic Services (CLS) Program – Contracted Providers
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	2/13/2015
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

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

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

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

The Alliance ensures that all delegated provider networks, subcontractors, and downstream subcontractors provide a Cultural and Linguisitc Services Program to Alliance Members and

mechanisms are in place to fulfill their responsibilities, including administrative capacity, technical expertise, budgetary resources for language assistance and culturally responsive servcies. The Alliance reviews and identitifies problematic areas and effective action is take to improve care.

PROCEDURE

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

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

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

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

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

3.2.3. Population level information about Alliance member language and cultural needs are shared through the required annual Cultural Sensitivity Training.

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

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

3.3.2. The Cultural and Linguistic Services Subcommittee monitors grievances regarding provider language capacity and reviews in-person and telephonic service requests. Reports are forwarded to the Quality Improvement Health Equity Committee/Utilization Management (QIHE/UMC).

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

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

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

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

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

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

4.5. At a minimum the Quality Improvement Department analyzes the capacity of its network to meet:

4.5.1. The language needs of individuals

4.5.2. The needs of members for culturally appropriate care

5. Based on findings of analysis described in 4.5 above the Quality Improvement Department develops a plan to address gaps identified as a result of the analysis if applicable

5.1. The Quality Improvement Department will address gaps based on the plan if applicable.

6. 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.
   6.1. All languages spoken at the office are listed below the provider listing, whether the provider is a Primary Care Provider or specialist.
   ~~6.2.~~ Member Services staff use this information to assist members in selecting an appropriate provider.
   6.2.
7. In the event that a Network provider, subcontractor or downstream subcontractor has religious or ethical objections to perform or otherwise support the provision of covered services, the Alliance will arrange for, coordinate, and ensure the member receives services in a timely manner through a provider with no moral objections.
   7.1. Members are notified in the member handbook of the right to access services from another provider.
   7.2. Members can call the Member Services Department for assistance in identifying another provider or behavioral health provider. When appropriate, Member Services staff will refer the member to the Case Management Department or Behavioral health Department for care coordination support.

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DEFINITIONS / ACRONYMS

ECM: Enhanced Care Management
D-SNP: Dual Eligible Special Needs Plan
Limited English Proficient (LEP): A person that is unable to speak, read, write, or understand the English language at a level that permits him/her to interact effectively with health and social services agencies and providers.
QIHEC – Quality Improvement Health Equity Committee

AFFECTED DEPARTMENTS/PARTIES

Alliance Provider Network
Member Services
Provider Services
Quality Improvement
Vendor Management

REVISION APPROVAL HISTORY

2/13/2015, 3/24/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, **3/22/2022**, 3/21/2023, **03/19/2024**, 4/16/2025, **11/19/2025**, TBD

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RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

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

MONITORING

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

POLICY AND PROCEDURE

Policy Number	CLS-010
Policy Name	Cultural and Linguistic Services Program: Staff Training and Assessment
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	2/13/2015
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

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

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

PROCEDURE

1. The Alliance creates and updates on an annual basis a Cultural Sensitivity Training that includes the following:
   1.1. Knowledge of the Alliance's policies and procedures related to language assistance.
   1.2. Instruction on working effectively with members and interpreters through all means of communication.

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

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

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

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

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

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

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

5.2. Human Resources ensures that designated multilingual staff are assessed by a qualified outside vendor.
5.2.1. Assessments are pass/fail. Staff who fail their departmental test for a certain non-English language will not be permitted to serve members in that language until they pass the assessment.
5.2.2. Human Resources will maintain a list of current multilingual employees including the language(s), testing date and clinical or non-clinical capacity.
5.2.3. Human Resources, or their designee, reviews the quality of multilingual staff communication with members through yearly reassessment.

5.3. Bilingual staff sign an attestation to confirm understanding of CHIA standards,

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

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

DEFINITIONS / ACRONYMS

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

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments
Alliance Provider Network

REVISION APPROVAL HISTORY

2/13/2015, 3/24/2016, 11/10/2016, 5/25/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/17/2022, 3/21/2023, **03/19/2024**, 4/16/2025, **11/19/2025,** TBD

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RELATED POLICIES AND PROCEDURES

CLS-001 Cultural and Linguistic Program Description

CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities
CLS-009 Cultural and Linguistic Services Program - Contracted Providers
CLS-011 Monitoring of Cultural and Linguistic Services
HR-020 Assessing Language Skills – New Hires, Promotions & Annual Testing
HR-027-DEI Training Program
PH-005 Population Assessment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

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

MONITORING

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

POLICY AND PROCEDURE

Policy Number	CLS-011
Policy Name	Compliance Monitoring of Cultural and Linguistic Services Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	2/13/2015
Administrative Oversight Committee Approval Date	~~11/19/2025~~TBD

POLICY STATEMENT

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

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

The Alliance's Quality Improvement (QI) Department is responsible for monitoring the Cultural and Linguistic Services Program and evaluating its effectiveness. The Alliance's Quality

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

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

PROCEDURE

1. Language Assistance Services Monitoring

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Multilingual Staff and Vendor Language Capacity. The Alliance also monitors the linguistic capabilities of multilingual staff and vendor interpreters.

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

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

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

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

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

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

2.2.2. The QI Department requests and reviews monthly updates and an annual summary of certifications of interpreters used through interpreter services vendors.

2.2.2.1. These reports include the interpreter's name or identification number, language(s) spoken, the latest assessment or review completion date, and linguistic assessment/evaluation grading of the accuracy and proficiency of the interpreter.

2.2.3. The Alliance tracks client feedback on quality of interpreter services vendors, requests resolution from vendors, and presents trends to vendors at quarterly joint operations meetings.

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

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

3.1. Annually, the Alliance assesses the cultural, ethnic, racial and linguistic needs of its members. Elements assessed include:

3.1.1. Member preferred language

3.1.2. Member Race and ~~/~~Ethnicity

3.1.3. Member Cultural Needs

3.2. Annually, the Alliance assesses the characteristics of network providers and determines if the member needs are met by the network. Elements assessed include:

3.2.1. Provider language capacity

3.2.2. Member survey results

3.2.3. Cultural and linguistic services grievances

3.3. Adjustments are made to the practitioner network to meet the cultural, ethnic, racial, and linguistic needs of members within defined geographical areas. Adjustments may include:

3.3.1. Requiring the completion of the cultural competency and sensitivity training

3.3.2. Making culturally and linguistically appropriate health education materials available to providers

3.3.3. Recruiting practitioners whose cultural and ethnic background are similar to the underrepresented member population.

3.3.4. The Alliance documents areas for improvement and recommendations in the annual "Availability of Practitioners to meet the Cultural Needs and Preferences and Preferences" report.

4. C&L Monitoring Reporting Structure

4.1. The QI Department receives all monitoring reports.

4.2. Reports are presented to the CLSS and forwarded to the QIHE/UMC for input and approval.

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

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

DEFINITIONS / ACRONYMS

CAC: Community Advisory Committee
CAP" Corrective Action Plan
CAHPS: Consumer Assessment of Healthcare Providers & Systems
CG – CAHPS: Clinician and Group CAHPS survey
CLS: Cultural and Linguistic Services
CLSS: Cultural and Linguistic Services Subcommittee – a subcommittee of the QIHE/UMC
DHCS: Department for Health Care Services
D-SNP: Dual Eligible Special Needs Plan
JOM: Joint Operations Meetings
MRR: Medical Record Review
LEP: Limited English Proficiency
PQI: Potential Quality Issues: An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issue exists.
QI: Quality Improvement
QIHE/UMC: Quality Improvement Health Equity/Utilization Management Committee – a committee of the Alliance Board of Governors
QOL: Quality of Language

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

REVISION APPROVAL HISTORY

2/13/2015, 3/24/2016, 3/9/2017, 5/25/2017, 10/12/2017, 5/3/2018, 3/21/2019, 3/19/2020, 3/18/2021, 11/23/2021, 3/22/2022, 3/21/2023, **12/19/2023**, **03/19/2024**, **4/16/2025**, **11/19/2025**, TBD

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RELATED POLICIES AND PROCEDURES

CLS-008	Member Assessment of Cultural and Linguistic Needs
CLS-009	CLS Program - Contracted Providers
CLS-010	CLS Program - Staff Training
CLS-011	CLS Program Compliance Monitoring
G&A-003	Grievance Receipt, Review and Resolution
QI-101	Quality Improvement Program

QI-104	Potential Quality of Care Issues
QI-105	Facility Site Review (FSRs), Medical Record Review (MRRs), and Physical Accessibility Review Surveys (PARS)
QI-117	Member Satisfaction Survey
QI-118	Provider Satisfaction Survey

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None.

REFERENCES

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

MONITORING

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

POLICY AND PROCEDURE

Policy Number	CM-002
Policy Name	Complex Case Management Plan Development and Management
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Director of Social Determinants of Health
Line(s) of Business	MCAL, IHSS
Effective Date	6/1/2012
Administrative Oversight Committee Approval Date	~~5/20/2026~~TBD

POLICY STATEMENT

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

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

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

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

The Alliance will:

1. Ensure that all Alliance members are selected, as appropriate, for Complex Case Management.
2. Develop an individualized Care Plan based on an analysis of the General Assessment and Specialty Assessments, as applicable, and in collaboration with the member and/or their representative, and care providers using Person-Center Planning.
    - Person-Centered Planning:

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

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

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

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

PROCEDURE

Scope:

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

Care Plan Development

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

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

Collaboration and Communication with the Member ~~and Provider~~

1. Once the Care Plan has been developed, the CM and/or SW shall schedule a time and create a Contact Member task to self, if not already done at the close of the Assessment, to review the plan with the member and obtain agreement on the goals and interventions. During the follow-up call, motivational interviewing techniques should be used to engage the client and obtain agreement on the Care Plan. Changes to the Care Plan should be made as appropriate documenting member's readiness to change and agreement with the Plan.
2. After the Care Plan is agreed upon with the member, a letter summarizing CCM services and the Care Plan (member's self-management plan) should be mailed to the member and/or caregiver.

Collaboration and Communication with the Provider

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1. 1. ~~With the member's permission,~~ The provider of care (primary provider and/or specialist managing care) ~~should be~~is notified that the member is receiving care management services.

~~1.~~

2. A summary of draft Initial Care Plan is sent to the provider via fax with a request to review and provide input into the final Care Plan.

~~2.~~ The fax cover letter (attachment 2) defines the provider's role and responsibility in actively participating in the member's care via contribution to the member's care plan, and working with the case management department via coordination of care.

3. ~~For U~~updates to the Care Plans are updated as needed, upon which time ~~or the annual reassessments~~, the Providers are provided with the revised Care Plan to allow opportunities to provide input into the final Care Plan.
4. Providers are contacted as needed to collaborate on member's complex case management case for components including, but not limited to:
    a. Medication review
    b. Alternate contact phone numbers for members
    c. Clarification of plan of care with member
    ~~a.~~d. Referrals to specialists

Care Plan Management

1. The Care Plan, its goals and interventions schedule for completion shall guide the CM and/or SW in managing the case. Additionally, the member shall be provided the name and number of the CM to contact as needed.
2. In managing the case, the CM and/or SW shall:
    a. Evaluate cultural, linguistic needs, preferences, or limitations in building the Care Plan and interacting with the member.
    b. Evaluate visual and hearing needs, preferences, or limitations in building the Care Plan and interacting with the member.

c. Address the availability of caregiver resources and their involvement with the member.

d. Address available benefits and any needs for community and financial resources.

e. Provide the member with available programs, resources and program requirements based upon their and their caregiver's preferences and desired level of involvement in their plan of care.

f. Supporting and assisting the member in accessing all needed services and resources, including across the physical and behavioral health delivery system.

    1. Make and follow up on referrals to resources. Follow up on all referrals will be scheduled at the time of the referral and can be combined as part of the next monthly contact, if not considered urgent.

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

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

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

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

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

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

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

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

Additional CCM Care Plan Guidelines

1. All interactions with the member and/or providers of care concerning the Care Plan shall be documented in the Clinical Information System. In the event that a template or field entry is not available, Complex Note entries shall be used in the Clinical Information System.

2. In the absence of system generated recommendations of care the CM and/or SW will review applicable, evidenced-based guidelines published or referenced by the Alliance and/or from The National Guideline Clearinghouse (www.guideline.gov) and/or medical and behavioral healthcare specialty societies to determine the goals and interventions of the Care Plan. The Clinical Information System's recommendations are also based on professionally recognized standards of care, including industry standards and, where appropriate, based upon competent evidence-based practices such as the National Guideline Clearinghouse and other credible sources.
3. Care Plan development and monitoring time frame standards are as follows:
    a. Obtain consent to CCM services within 5 calendar days of completing all sections of the Assessment. If unable to contact member, Unable to Reach (UTR) protocols are followed.
    b. Complete Care Plan within 60 calendar days of enrollment. Enrollment is defined as when the member consents to Complex Case Management and a Complex Case is opened in the Clinical Information System.
    c. At least monthly contact from time of consent.
    d. Referrals are made within 5 calendar days of identifying need.
    e. Case closure within 90 days of Care Plan development unless otherwise extended at Case Rounds.

DEFINITIONS / ACRONYMS

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

Assessment Process: Assessment is a process of compiling data including claims and medication history, HRA data and member questions to provide the basis to analyze services needed and to assist in creating a care plan. There are numerous assessment tools that can be used to compile data. Alliance uses a General Assessment, Diabetes and Asthma Assessments and Health Risk Assessments for the SPD and ACC populations.

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

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

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

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

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

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

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

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
CM-003 Complex Case Management Plan Evaluation and Closure
CM-004 Policy and Procedure, Care Coordination of Services
CM-006 Internal Audit and Monitoring

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

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

REVISION APPROVAL HISTORY

12/05/2012, 3/1/2016, 1/4/2018, 5/3/2018, 04/16/2019, 05/21/2020, 05/21/2021, 09/16/2021, 03/22/2022, 6/20/2023, 6/12/2024**, 5/21/2025**, **9/17/2025**, 05/20/2026

Blue = materials updates

REFERENCES

1. DHCS Two Plan Model Contract Exhibit A, Attachment 11 Case Management and Coordination of Care, Section B
2. NCQA QI 5: Complex Case Management

MONITORING

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

ATTACHMENT 1

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

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

www.alamedaalliance.org

[Date]

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

Member ID: [Member ID]

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

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

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

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

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

The program is designed to help you:

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

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

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

We suggest that you:

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

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

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

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

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

Best of Health,
Health Care Services
Alameda Alliance for Health

Enclosed:

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

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ATTACHMENT 2

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

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

www.alamedaalliance.org

[Date]

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

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

Dear Provider,

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

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

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

We will address their special medical and psychosocial needs by:

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

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

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

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

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

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

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

Sincerely,
Health Care Services
Alameda Alliance for Health

Enclosed: Care Plan

POLICY AND PROCEDURE

Policy Number	CM-019
Policy Name	Private Duty Nursing Case Management For Members under the age of 21
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL, IHSS
Effective Date	09/17/2020
Administrative Oversight Committee Approval Date	~~5/20/2026~~TBD

POLICY STATEMENT

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

The Alliance will cover case management to assist Members under the age of 21 in gaining access to all medically necessary medical, Behavioral Health, dental, social, educational, and other services.

The Alliance will authorize and provide medically necessary PDN services, when:

- A member's CCS program eligibility is pending confirmation;
- A member with an established CCS eligible condition has only received authorization for a portion of the PDN hours from CCS; in such cases the Alliance will authorize the remaining hours if they are medically necessary to correct or ameliorate the member's condition. The Alliance can view the status of service authorization requests the CMS Net Provider Electronic Data Interchange (PEDI). IF CCS denies all or part PDN hours, the notice of action (NOA) informs the provider and family to resubmit the request to the member's MCP and include the NOA with their request;
- A member not enrolled in CCS, making the Alliance responsible for providing all medically necessary covered services; or

- CCS denies authorization for a medically necessary service unrelated to the CCS Eligible Condition, such as PDN that is medically necessary under EPSDT to correct or ameliorate the member's condition.

PROCEDURE

1. When an eligible member under the age of 21 is approved for PDN by the Alliance or CCS, a referral will be made to Case Management per the Alliance normal workflow.
2. When the Alliance has approved a plan enrolled EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services, the Alliance retains primary responsibility to provide Case Management for approved Private Duty Nursing services.
3. When CCS has approved a CCS participant who is an EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services for treatment of a CCS condition, the CCS Program has primary responsibility to provide Case Management for approved Private Duty Nursing services.
4. Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved Private Duty Nursing services, an EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal Private Duty Nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be the Alliance, CCS, or the Home and Community Based Alternatives Waiver Agency) to request case management for Private Duty Nursing services. The contacted Medi-Cal program entity must then provide Case Management Services as described above to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for Case Management. Members may decline case management services without impact to their authorized PDN services
5. Case management will reach out to the member once services are approved to:
    - provide the member with information about the number of PDN hours the member is approved to receive
    - coordinate services with the entity providing services for the member
    - assisting non-contracted providers with the process of enrolling to become a Medi-Cal member if needed
    - coordination of services if multiple providers are required to manage the member's PDN needs
6. If a member elects to not use all of the approved PDN services, the Alliance will document such within the members record with all applicable information.

Case Management Responsibilities
The Alliance remains primarily responsible for providing case management to arrange for all authorized PDN service hours. MCPs must use one or more Medi-Cal enrolled HHAs or INPs, or any combination thereof, to meet the member's authorized PDN service needs.

CCS Liaison
The CCS Liaison is the primary point of contact for the coordination of services between the MCP and county CCS Program.

~~6.~~ The CCS Liaison is familiar with this policy outlined in APL 26-009.

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DEFINITIONS / ACRONYMS

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

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

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

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

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

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Claims

RELATED POLICIES AND PROCEDURES

CM-033 Home and Community Based Services (Waiver Programs) - DDS
UM-008 Coordination of Care – California Children's Services (CCS)

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

9/17/2020, 1/21/2021, 03/22/2022, 6/20/2023, 6/12/2024, 5/21/2025, 5/20/2026

REFERENCES

APL 20-012
APL 26-009
Social Security Act (SSA), section 1905(r) and Title 42 of the United States Code (USC), section 1396d(r).

MONITORING

Annually

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE TEMPLATE

Policy Number	CM-046
Policy Name	Plan Responsibilities IHCP and American Indian Members
Department Name	Case Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCal. Group Care
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

The purpose of this policy is to outline the responsibilities of the Alameda Alliance for Health (Alliance) as it pertains to Indian Health Care Providers (IHCPs) and American Indian members assigned to the Alliance. The requirements outlined in this policy align with the Contract between the Alliance and the Department of Health Care Services (DHCS), and applicable All Plan Letters (APLs), as well as state and federal regulations.
American Indian Medi-Cal Members are not required to enroll in a managed care plan (MCP), except in the case of County Organized Health Systems (COHS) or Sign Plan Model counties. American Indians who are voluntarily enrolled in a MCP in non-COHS or non-Single Plan Model counties are permitted to disenroll from the MCP, without cause, even in instances where their aid code is subject to mandatory managed care enrollment. American Indians who disenroll from a MCP will receive services under the Fee-for-Service (FFS) delivery system.

PROCEDURE

1 **American Indian Member Rights and Protections**

1.1 An American Indian Alameda Alliance (Alliance) Member can request to receive services from an IHCP and can choose an IHCP within the Alliance's Network as a Primary Care Provider (PCP).

1.1.1 The Alliance permits an American Indian Alliance Member to obtain Covered Services from an out-of-network IHCP without requiring a referral from a network PCP or prior authorization.

1.1.2 IHCPs, whether in the Alliance's Network or out-of-network, can provide referrals directly to Network Providers without a referral from a network PCP or prior authorization.

1.2 An American Indian Alliance Member may receive services from an out-of-network IHCP even if there are in-network IHCPs available. When an American Indian Alliance Member requests to receive services from an IHCP, and there is no in-network IHCP available, then the Alliance will assist the member in locating and connecting with an out-of-network IHCP.

1.3 American Indian Alliance members are not subject to enrollment fees, premiums, deductibles, copayments, cost sharing, or other similar charges. The Alliance is prohibited from imposing such fees or charges on any American Indian Alliance member who receives an item or service directly from an IHCP or through a referral to an IHCP, or reduce payments due to a provider, including an IHCP, by the amount of any enrollment fee, premium, deductible, copayment, cost sharing, or similar charge.

2 IHCP Rights and Protections

2.1 The Alliance is proactive in developing processes designed to enhance collaboration with IHCPs and resolve IHCP inquiries within applicable authorization timeframes, including expedited authorizations.

2.2 Existing rights and protections from IHCPs, on the topics of enrollment, contracting, credentialling and site review, and claims payment.

3 IHCP Provider Enrollment, Contracting, and Credentialing

3.1 If an IHCP is providing Medi-Cal covered services, including transportation, to an American Indian Alliance member, the Alliance will ensure that the IHCP is enrolled in the Medi-Cal program.

3.1.1 Providers can enroll through either the state-level enrollment pathway or the Alliance enrollment pathway.

3.2 The Alliance will inform an IHCP about the following reimbursement provision if contacted by an ICHP regarding enrollment:

3.2.1 An IHCP facility must enroll through the state-level enrollment pathway in order to receive reimbursement at the All-Inclusive Rate (AIR) or Prospective Payment System (PPS), and to receive the Medi-Cal Fee-for-Service (FFS) reimbursement for Medi-Cal Managed Health Care Plan (MCP) carved-out-services, such as dental services.

3.3 The Alliance will ensure that the individual practitioners who provide services at an IHCP facility are enrolled in Medi-Cal as an Ordering, Referring, and Prescribing (ORP) Provider.

3.4 If an IHCP provides transportation services to non-American Indian members assigned to the Alliance, the IHCP must be enrolled in the Medi-Cal program as a transportation provider and must contract with the MCP and/or the MCP's delegated transportation provider.

3.5 In the event the Alliance contracts with any Tribal Health Programs, it will not require the licensure of a health professional employed by a Tribal Health Program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state.

3.6 The Alliance's contract with IHCPs cannot be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law; including the following requirements:

- 3.6.1 No term or condition of the MCP's contract with an IHCP, or any addendum thereto, can be construed to require the IHCP to serve MCP Members who are ineligible for services from the IHCP. The MCP must acknowledge that pursuant to 45 CFR 80.3(d), a Member shall not be deemed subjected to discrimination by reason of their exclusion from benefits limited by federal law to Members eligible for services from the IHCP. The IHCP acknowledges that the nondiscrimination provisions of federal law may apply.
- 3.6.2 Certain federal laws and regulations apply to IHCPs, but not other Providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCP Members.
- 3.6.3 IHCPs cannot be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the MCP will be held harmless from liability. MCP contracts with IHCPs, or any addendum thereto, cannot be interpreted to authorize or obligate such Provider, or any employee of such Provider, to perform any act outside the scope of their employment.
- 3.6.4 In the event of any dispute arising under the MCP's contract or agreement with an IHCP, or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the MCP's contract with an IHCP, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.
- 3.6.5 The MCP's contracts with IHCPs, and all addenda thereto, must be governed and construed in accordance with federal law. In the event of a conflict between such contract, and all addenda thereto, and federal law, federal law prevails. Nothing in the MCP's contract with an IHCP, or any addendum thereto, can subject an IHCP to state law to any greater extent than state law is already applicable.
- 3.6.6 To the extent the MCP imposes any medical quality assurance requirements on its Network IHCPs, any such requirements applicable to the IHCP are subject to Section 805 of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. § 1675).
- 3.6.7 Nothing in the MCP's contract with an IHCP, or in any addendum thereto, can constitute a waiver of federal or tribal sovereign immunity.

3.7 The Alliance attempts to contract with each IHCP in its service area and submit documentation to DHCS of all efforts to contract with IHCPs, including as applicable, why the Alliance is unable to contract with an IHCP in its service area.

3.7.1 The Alliance includes IHCP data in its 274 file submission to demonstrate compliance with Network requirements.

3.8 IHCPs are not required to contract with the Alliance or with its Subcontractors as a Network Provider in order to be reimbursed by either the Alliance or its Subcontractors for services provided to an American Indian member who is assigned to the Alliance.

3.9 The Alliance will provide acknowledgement of receipt in a written notice to the IHCP within 15 days of receiving a Network Provider application. (See CRE-002)

3.10 The Alliance is required to ensure that IHCPs contracting as Network Providers are properly credentialed and re-credentialed, in accordance with the Contract and applicable DHCS APL 22-013 and any subsequent updates.

4 IHCP Claims and Reimbursement

4.1 The Alliance must provide payment of claims to IHCP in a timely and expeditious manner in accordance with federal and state law, and DHCS APL 23-020. (See CLM-001)

4.2 The Alliance must process claims from IHCPs in accordance with federal law, which does not permit the denial of claims submitted by an IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

4.3 The Alliance will reimburse an IHCP in accordance with the federal standard of payment, which includes payment of 90 percent of all clean claims (i.e., claims that require no additional information) within 30 calendar days or receipt, and payment of 99 percent of all clean claims within 90 calendar days of receipt). (See CLM-001)

4.4 The Alliance will reimburse Tribal Health Programs, Including Indian Health Service Memorandum of Agreement and Tribal Federally Qualified Health Centers (FQHCs) at the federally established AIR as noted in DHCS APLs 17-020 and 21-008.

4.5 The Alliance will reimburse an Urban Indian Organization enrolled in Medi-Cal as FQHCs through the PPS.

4.6 The Alliance or its Subcontractor will reimburse an IHCP that is enrolled in the Medi-Cal program for transporting an American Indian member that is assigned to the Alliance, to an IHCP, regardless if the IHCP is contracted with the Alliance, as long as the transportation takes place using a PAVE approved transportation provider. (See UM-016)

4.7 If an IHCP provides transportation services to non-American Indian members assigned to the Alliance, the IHCP must be enrolled in the Medi-Cal program as a transportation provider and must contract with the MCP and/or the MCP's delegated transportation provider.

4.8 The Alliance will provide reimbursement for transportation related travel expenses as described in 42 Code of Federal Regulation (CFR) section

440.170(a)(1) and (3), and DHCS APL 22-008 and subsequent updates. (See UM-016)

5 Tribal Liaison

5.1 The Alliance must have an identified tribal liaison dedicated to working with each contracted and non-contracted IHCP in its service area, and is responsible for coordinating referrals and payments for services provided to American Indian members who are qualified to receive services from an IHCP. The responsibilities of the tribal liaison include but are not limited to the following:

- 5.1.1 Providing information to IHCPs regarding enrollment and disenrollment of American Indian MCP members;
- 5.1.2 Coordinating care with in- and out-of-network IHCPs for American Indian MCP Members;
- 5.1.3 Ensuring access to care with in- and out-of-network IHCPs for American Indian MCP Members;
- 5.1.4 Providing assistance to IHCPs and American Indian MCP Members with accessing appropriate transportation given logistical and geographical barriers unique to tribal communities;
- 5.1.5 Providing case management for American Indian MCP Members that involves in- and out-of-network IHCPs;
- 5.1.6 Assisting IHCPs with Provider relations services, claims and payment assistance and resolution, and Member services;
- 5.1.7 Providing support in obtaining grievance, appeal, and State Hearing services to IHCPs in cases that impact American Indian MCP Members;
- 5.1.8 Providing benefits and services navigation and coordination, including but not limited to those for Foster Care, Community-Based Adult Services, Enhanced Care Management, Community Supports, Behavioral Health, Health Education, Home and Community Based Services, California Children's Services (CCS), etc., for IHCPs in order to provide full-spectrum services to American Indian MCP Members;
- 5.1.9 Assisting internal MCP liaisons in instances that involve IHCPs and/or American Indian MCP Members and the other liaison's respective services and program, in particular the Foster Care liaison given the observed disproportionate representation of American Indian youth in the Foster Care system; as well as the liaisons for Long-Term Services and Supports, Transportation, CCS, Regional Center, Dental, and IHSS; and
- 5.1.10 Providing assistance to IHCPs regarding Medi-Cal program Provider enrollment and MCP contracting, credentialing, and Facility Site Reviews.

5.2 The tribal liaison will attest to the completion of and document completion of the following trainings:

- 5.2.1 Cultural Humility training from the California Governor's Office of the Tribal Advisor;

5.2.2 Overview of Trauma-Informed Care and Historical Trauma training from the Indian Health Service (IHS); and
5.2.3 Other relevant trainings as they are developed and noted by DHCS.

5.3 The Alliance strongly encourages its tribal liaison to commit to the following activities to enhance relationships between the Alliance, IHCPs, and American Indian members assigned to the Alliance:

5.3.1 Providing assistance to the MCP's Member Services department in situations involving American Indian MCP Members;
5.3.2 Representing the MCP and providing assistance to Subcontractors to address inquiries and/or instances involving American Indian MCP Members;
5.3.3 Participating in the MCP Community Advisory Committee and other MCP committees that potentially impact American Indian MCP Members;
5.3.4 Attending and participating in tribal consultations involving tribes within the MCP's service area;
5.3.5 Attending and participating in DHCS' Tribal and Designees of Indian Health Programs Quarterly Meeting, and other relevant meetings;
5.3.6 Developing tribal specific outreach and educational materials;
5.3.7 Hosting marketing events and developing marketing materials focused on tribal health as permitted;
5.3.8 Collaborating with other MCP tribal liaisons to discuss best practices, lessons learned, and sharing of information and resources;
5.3.9 Collaborating with local tribal communities on the development of regional and culturally appropriate trainings for MCP staff; and
5.3.10 Having knowledge and consideration of Indigenous Determinants of Health when determining quality metrics and data reporting.

DEFINITIONS / ACRONYMS

American Indian – a Member who meets the criteria for an "Indian" under 42 Code of Federal Regulations (CFR) section 438.14(a).

All Plan Letter (APL) – a binding document that has been dated, numbered, and issued by Department of Health Care Services (DHCS) that provides clarification of Contractor's contractual obligations, implementation instructions for Contractor's contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Indian Health Care Provider (IHCP) – a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC section 1603.

Network Provider – any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

Subcontractor – an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Tribal Health Program – an American Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Health Service under the Indian Self-Determination and Education Assistance Act and is define in 25 USC section 1603(25).

Tribal Federally Qualified Health Center (Tribal FQHC) – a Tribal Health Program funded under the authority of Public Law 93-638 at 25 USC sections 5301 et seq. These Health Programs have elected to participate in the Medi-Cal Tribal FQHCs and are subject to the payment terms of DHCS APL 21-008. Reimbursement of Tribal FQHCs is through an Alternative Payment Methodology (APM), which is set at the federal Indian Health Service All-Inclusive Rate. The APM rate is updated annually and published in DHCS APL 21-008, Attachment #1. A list of Tribal FQHCs is published in DHCS APL 21-008, Attachment #2.

Urban Indian Organization – a nonprofit corporate body situated in an urban center, governed by an urban American Indian controlled board of directors, as defined in 25 USC section 1603(29). Urban Indian Organizations participate in Medi-Cal as Tribal Federally Qualified Health Centers (Tribal FQHCs) or community clinics and are reimbursed via the Prospective Payment System or at Fee-For-Service rates.

AFFECTED DEPARTMENTS/PARTIES

Compliance
Claims
Credentialing
Provider Services and Contracting
Utilization Management

RELATED POLICIES AND PROCEDURES

CRE-002 Credentialing and Re-Credentialing of Individual Practitioners

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

Draft 10/08/2024

REFERENCES

DHCS APL 24-002
DHCS APL 22-013
DHCS APL 22-017
DHCS APL 23-020
DHCS APL 17-020
DHCS APL 21-008
Title XVIII of the Social Security Act
42 Code of Federal Regulation Section 440.170(a)(1) and (3)

MONITORING

The **Case Management department** is responsible for monitoring the successful execution of responsibilities by the Tribal Liaison. Monitoring activities include:

1. Maintenance of applicable communication records with contracted and non-contracted IHCP in its service area, including, but not limited to, meeting notes and care management documentation
2. At least annual review of Tribal Liaison roles and responsibilities, as defined in job description

POLICY AND PROCEDURE

Policy Number	BH-XXX
Policy Name	Behavioral Health Data Sharing
Department Name	Behavioral Health
Department Officer	Dr. Carey., MD
Policy Owner	Andrea DeRochi, BH Manager
Line(s) of Business	MCAL
Effective Date	TBD
Subcommittee Name	QIHEC
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

Alameda Alliance for Health shall maintain processes to support secure, timely, and bi-directional exchange of minimum necessary member information with behavioral health partners in accordance with Department of Health Care Services All-Plan Letter, (APL) 26-004. Sharing data with behavioral health partners in real-time will support referrals, care coordination, closed loop referrals and care transitions.

PROCEDURE

1 Data Sharing Governance

1.1 The Alliance shall maintain governance processes for behavioral health data sharing that define the purpose, scope, responsible departments, privacy requirements, operational roles, and oversight mechanisms for data exchange with Alameda County Behavioral Health (ACBH), Drug Medi-Cal Organized Delivery Systems (DMC-ODS), Network Providers, Community Based Organizations (CBOs), and other authorized Medi-Cal Third Party Entities.

1.2 The Alliance shall require bidirectional sharing of minimum necessary Member data with ACBHs and DMC-ODS for care coordination in real time, to the extent allowed by federal and state law and subject to Health Information Portability and Accountability Act (HIPAA) minimum necessary standards when applicable.

1.3 The Alliance shall ensure behavioral health data sharing is used only for permitted purposes, including treatment, payment, health care operations, care coordination, referrals, transitions of care, population health management, quality monitoring, and required reporting activities.

1.4 The Alliance shall define "real time" data exchange consistent with the Data Exchange Framework (DxF) concept of sharing information as soon as it becomes available and without intentional or programmatic delay when needed to support care decisions.

1.5 The Alliance shall maintain evidence of governance review, policy approval, operational implementation, and corrective action when gaps in data sharing compliance are identified.

2 Real-time Data Exchange

2.1 The Alliance shall maintain operational workflows to send and receive minimum necessary information in accordance with Health Information Portability and Accountability Act (HIPAA) minimum necessary standards. Real time information sharing shall be established with ACBHs, DMC-ODS, Network Providers, CBOs, and other authorized entities when needed to support service delivery, referrals, closed-loop referrals, care coordination, care transitions, and treatment planning.

2.2 Information exchanged may include member demographic information, Admission/Discharge/Transfer (ADT) event notifications, services, and treatment provided, diagnoses, assessments, medications prescribed, laboratory results, and other data elements necessary to support care coordination and treatment, subject to applicable privacy and consent requirements.

2.3 Real-time data exchange is consistent with DxF requirements of "timely and frequent" and requirements outlined in DxF standards OPP-8, OPP-9 and OPP-12.

3 Memorandum of Understanding Requirements (MOUs)22

3.1 The Alliance shall establish, maintain, or support execution of Memoranda of Understanding (MOUs) with applicable ACBH and DMC-ODS that serve Alliance members to ensure member care is coordinated, and continuity of care is supported.

3.2 MOUs shall describe real-time data exchange processes, referral workflows, closed-loop referral requirements, care coordination expectations, ADT notification processes, Member roster exchange, privacy and consent responsibilities, and escalation processes for unresolved data-sharing issues.

3.3 MOUs and related workflows shall support the No Wrong Door Initiative by enabling appropriate referral and information-sharing processes between the Alliance, ACBH, DMC-ODS, and other applicable entities.

3.4 The Alliance shall review MOUs and related operational procedures when DHCS guidance changes, when data-sharing workflows are modified, or when oversight identifies a gap in implementation.

3.5 The Alliance shall retain documentation of executed MOUs, amendments, workflow documents, meeting notes, implementation trackers, and corrective action follow-up related to MOU compliance.

4 Admission, Discharge, and Transfer (ADT) Event Notifications

4.1 The Alliance shall support processes to receive, use, and transmit ADT event notifications in real time when available, legally permitted, and operationally supported.
4.2 ADT event notifications shall be used to support timely outreach, care coordination, care transitions, follow-up, identification of service needs, and coordination with ACBH, DMC-ODS, Network Providers, facilities, and other authorized entities.
4.3 The Alliance may use approved intermediaries, including Qualified Health Information Organizations (QHIOs), Health Information Exchanges (HIEs), or technology vendors, to submit rosters and receive ADT event notifications when such intermediaries support compliant and secure exchange of Health and Social Services Information (HSSI).
4.4 The Alliance shall review provider, facility, and vendor agreements to determine whether ADT exchange obligations are addressed and whether amendments, workflow documents, or other agreements are needed to support compliance.
4.5 ~~When ADT agreements are not in place, the Alliance shall document the gap, identify accountable operational owners, maintain a remediation plan to establish agreements and monitor progress toward implementation within 6 months time.~~ When ADT agreements are not in place, the Alliance shall document the gap, identify accountable operational owners, maintain a remediation plan to establish agreements and monitor progress toward implementation within 6 months.
~~4.5~~

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5 Member Rosters

5.1 The Alliance shall maintain processes for sharing up-to-date Member rosters with applicable ACBH and DMC-ODS, at least monthly when required and when permitted by federal and state law. 3
5.2 For purposes of this policy, “up-to-date” means a list of individuals who received services within the last ninety (90) days, consistent with the APL review criterion and APL source language.
5.3 Roster exchange shall be limited to the minimum necessary information required for the purpose of the exchange and shall comply with applicable privacy, security, and consent requirements.
5.4 The Alliance may use approved intermediaries, including HIEs, QHIOs, or technology vendors, to support roster exchange and related data exchange activities.
5.5 The Alliance shall maintain documentation of roster-sharing frequency, responsible operational owners, transmission mechanisms, known exclusions, consent-related limitations, and corrective action when roster exchange requirements are not met.
5.6 Memorandum of Understanding Requirements the sub description

6 Consent Management

6.1 The Alliance shall use the Authorization to Share Confidential Medi-Cal Information (ASCMI) Form as the standardized consent-to-disclose information form when Member consent is required by federal or state law.
6.2 The Alliance shall distinguish circumstances where Member consent is not required for treatment, payment, and health care operations from circumstances where Member consent is required, including certain disclosures involving 42 CFR Part 2 substance use disorder information, housing information, or other sensitive information requiring authorization.
6.3 The Alliance shall maintain procedures for collecting, receiving, storing, tracking, honoring, and integrating ASCMI consent information at the plan level to support provider-level submissions and appropriate data-sharing decisions.
6.4 The Alliance shall maintain processes for consent revocation, including receipt and processing of the ASCMI Revocation Form when a Member revokes a previously granted authorization.
6.5 The Alliance shall recognize electronic signatures when legally permissible and shall accept wet signatures when required or operationally appropriate.
6.6 When services involve minors, conservatorships, legal guardians, or circumstances requiring consent from different authorized individuals, the Alliance and its providers shall determine the appropriate individual from whom consent must be obtained before sharing information when consent is required.
6.7 Consent-related records shall be retained in accordance with applicable record retention requirements and shall be available for compliance monitoring, privacy review, and audit readiness activities.

7 Data Sharing for Required State and Federal Reporting

7.1 The Alliance shall share Member and encounter data necessary to support required state and federal quality, accountability, monitoring, and reporting obligations in compliance with applicable federal and state law.
7.2 Reporting-related data may include Member demographic information, ADT event notifications, services, and treatment rendered, diagnoses, assessments, medications prescribed, pharmacy claims data, laboratory results, encounter data, and other information required for quality, accountability, and monitoring reports.
7.3 Data sharing for state and federal reporting does not need to occur in real time when the purpose of the exchange is reporting rather than immediate care coordination.
7.4 The Alliance shall support reporting requirements such as DHCS Managed Care and Behavioral Health Plan accountability reporting, CMS Core Set measures, quality performance measures, external quality review activities, and population needs assessments when applicable.
7.5 The Alliance shall maintain documentation showing reporting data sources, responsible departments, file exchange methods, reconciliation processes, and corrective actions when reporting-related data exchange gaps are identified.

8 **Subcontractor, Downstream Entity, and Network Provider Accountability**

8.1 The Alliance shall communicate applicable APL 26-004 requirements to Subcontractors, Downstream Subcontractors, Network Providers, delegated entities, vendors, and other impacted entities as appropriate.

8.2 The Alliance shall ensure that applicable downstream entities comply with state and federal laws, contract requirements, privacy and security obligations, data-sharing requirements, consent requirements, and DHCS guidance relevant to behavioral health data sharing.

8.3 The Alliance shall review Subcontractor, Downstream Subcontractor, Network Provider, vendor, and other applicable agreements to determine whether data-sharing, ADT, roster, consent, reporting, privacy, and oversight obligations are sufficiently addressed.

8.4 When contracts or agreements do not adequately address APL 26-004 requirements, the Alliance shall document the gap and coordinate updates, amendments, workflows, notices, or other remediation steps as appropriate.

8.5 The Alliance shall maintain oversight processes, including monitoring reports, audits, compliance reviews, delegation oversight, corrective action plans, and follow-up documentation when noncompliance is identified.

9 **Compliance, Oversight and Monitoring**

9.1 The Alliance shall periodically review and update this policy and related operational procedures to ensure continued compliance with APL 26-004 and related federal and state requirements.

9.2 The Alliance shall maintain compliance evidence including policy approvals, procedure documents, MOU documentation, data exchange workflow materials, roster-sharing records, consent management records, monitoring reports, audit results, corrective action plans, training or communication records, and provider/subcontractor oversight records.

9.3 The Alliance shall monitor compliance through internal audits, operational reviews, data exchange reports, privacy reviews, IT assessments, provider oversight activities, delegation oversight, corrective action tracking, and regulatory submission readiness reviews.

9.4 The Alliance shall communicate identified noncompliance to accountable operational areas and track remediation through completion.

9.5 The Alliance shall support DHCS review and enforcement readiness, including focused monitoring, corrective action plans, and sanctions risk mitigation when applicable.

DEFINITIONS / ACRONYMS

Admission, Discharge, and Transfer (ADT) Event Notification	Electronic notification when an admission, discharge, or transfer event occurs.
Authorization to Share Confidential Medi-Cal Information (ASCMI) Form	The standardized member consent form required by DHCS for the Alliance to share specific behavioral health and housing information.

ASCMI Revocation Form	The standardized form used when a member revokes or changes a previously granted ASCMI consent for information sharing.
Behavioral Health Plan (BHP)	County behavioral health delivery system responsible for specialty mental health and/or substance use disorder services, as applicable.
Drug Medi-Cal (DMC) County	County entity responsible for Drug Medi-Cal related service delivery and coordination, as applicable.
DxF	Data Exchange Framework
Health Information Exchange (HIE)	Electronic sharing of health information between organizations to support patient care, coordination, and health system operations.
Health and Social Services Information (HSSI)	Health care and social services information shared among partners to support coordinated whole-person care.
Minimum Necessary	Information limited to what is necessary to accomplish the permitted purpose, subject to HIPAA minimum necessary standards when applicable.
Real-Time Exchange	Sharing information as soon as it becomes available and without intentional or programmatic delay when needed to support care decisions.
Subcontractor / Downstream Subcontractor	An entity responsible for performing delegated or contracted functions on behalf of the Alliance or another subcontracted entity.
Network Provider	A contracted provider or provider organization participating in the Alliance network.
No Wrong Door	A DHCS initiative intended to support access and referral across behavioral health systems without unnecessary delay.
Dual Consent	A scenario in which different authorized individuals may be required to consent for different services or distinct types of information, such as when coordinating services for minors or individuals under conservatorship.

AFFECTED DEPARTMENTS/PARTIES

[

- Behavioral Health
- Care Management
- Utilization Management
- Population Health
- Quality Improvement
- Compliance
- Privacy Office
- Information Technology
- Provider Services
- Contracting
- Credentialing
- Member Services
- Analytics
- Network Providers
- Delegated Entities
- Subcontractors
- Downstream Subcontractors
- ACBH
- DMC-ODS
- Other Medi-Cal Third Party Entities

RELATED POLICIES AND PROCEDURES

[List related Policies – if there are none, write "none"]

- DHCS APL 26-004, Behavioral Health Data Sharing
- BHIN 26-013 Behavioral Health Data Sharing
- Data Exchange Framework (DxF) Policies and Procedures, including OPP-8, OPP-9, and OPP-12 as applicable
- BH-001 Care Coordination Behavioral Health
- CMP-201 Minimum Necessary Use & Disclosures (v.7)
- CMP- 217 Type of Data Sharing Agreements
- CMP-400 Delegation Oversight
- CMP-401 Subcontracting Relationships and Delegation
- Alliance MOU with Alameda County Behavioral Health
- CalHHS Data Exchange Framework Policy and Procedure

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

[List related documents - if there are none, write "none"]

Version	Date	Description of Change	Author/Owner
1.0	XXX	Initial policy creation to address APL 26-004 Behavioral Health Data Sharing requirements. including real-time exchange, MOUs, ADT notifications, member rosters, consent management, reporting, subcontractor/provider accountability, and monitoring.	Health Care Services – Behavioral Health

REVISION APPROVAL HISTORY

[List revision dates starting with original effective date – this is the date that revisions were approved at AOC, and is a running list of approval dates from AOC]

REFERENCES

[List references such as regulatory citations- if there are none, write "none"]

MONITORING

[Describe the supervising activities in progress to ensure they are on-course and on-schedule in meeting the objectives and performance targets of this policy. This should not be left blank.]

POLICY AND PROCEDURE

Policy Number	UM-001
Policy Name	Utilization Management Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director of Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	11/02/2004
Administrative Oversight Committee Approval Date	~~5/20/2026~~TBD

POLICY STATEMENT

I. Alameda Alliance for Health ("The Alliance") ensures appropriate utilization of all healthcare services including mental health and substance use disorders for members, and compliance with the applicable State and Federal regulations.

II. The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to CA Health and Safety Code 1367.01 and 42 CFR 438.900(d).

III. The Alliance Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC) oversees the development, implementation, and effectiveness of the Quality Improvement Health Equity (QIHE) Program and is accountable to the Alliance Board of Governors. ~~. The QIHEC oversees subcommittees including the Utilization Management Committee.~~ The QIHE/UMC is chaired by the Chief Medical Officer (CMO) and vice-chaired by the Medical Director of Quality.

IV. The Alliance reviews/revises the Utilization Management (UM) Program and UM policies at least annually to ensure requirements and guidelines are adequately described for UM activities to facilitate appropriate utilization of health services including behavior health and substance use disorders.

a. The UM Program Description, Program Evaluation and Workplan are reviewed and updated at least annually and submitted for review and approval through the ~~Utilization Management Committee (UMC,)~~ Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC~~,~~) and the Board of Governors (BOG.) Significant program changes may also be reflected in a revised Program Description/Workplan during the year.

b. UM policies and procedures are reviewed and revised at least annually and as needed to reflect new policies/procedures in response to new APLs, other regulatory requirements, or business needs. They are submitted for review

and approval through the ~~Utilization Management Committee (UMC,)~~ Quality Improvement Health Equity/ Utilization Management Committee (QIHE/ UMC,) and the Board of Governors~~,~~ (BOG.)

V. The Alliance UM program shall include the following elements:

~~b.~~a. Authorization is not required prior to the provision of emergency services and care needed to stabilize a Member's emergent medical condition.

~~c.~~b. The Alliance covers all emergency room services and does not deny any emergency room claims.

~~d.~~c. Qualified staff will be responsible for the UM program including development, implementation, and medical policy including the designation of a physician to be involved in the UM Program implementation and a designated behavior health practitioner involved in the behavior health aspects of the UM program.

~~e.~~d. All UM decisions involving medical, surgical, behavior health or substance use disorders are based on medical necessity, appropriateness of care and services, by reviewing either/or clinical notes from the requesting provider, or adjunct clinical information obtained by using medical records, or labs available to the Alameda Alliance for Health, and the Member's covered services.

~~f.~~e. There is separation of medical decisions from fiscal and administrative management to assure that those medical decisions will not be unduly influenced by fiscal and administrative management:

~~ii.~~i. The Alliance distributes an affirmative statement to all practitioners, providers, staff, and members regarding incentives to ensure appropriate utilization and discourage underutilization.

~~iii.~~ii. The Alliance does not use incentives to encourage barriers to care and service.

~~iv.~~iii. The plan will ensure that a Medical Director's authorization decisions avoid any conflict of interest situations.

~~h.~~f. Second opinions from a qualified health professional are at no cost to Medi-Cal or fee-for service health plan in accordance with the AAH policy and procedure for Second Opinion (UM-005)

~~i.~~g. The Alliance and its delegates will maintain evidence-based criteria and apply the UM hierarchy criteria that was approved by the Alliance's QIHE/UMC, for approving, modifying, deferring, and denying requested services.

~~ii.~~i. The UM hierarchy criteria:

~~2.~~1. Regulatory and contractual requirements

- Regulatory requirements include WPATH guidelines for Transgender Care

- Regulatory requirements include the use of LOCUS/CALOCUS, ASAM, American Psychiatric Association and American Psychological Association.
- Medicare guidelines

~~3.~~2. Evidence based guidelines.
~~4.~~3. Alliance specific guidelines
~~5.~~4. National medical association consensus
~~6.~~5. Independent Medical Review (UM-046)
~~7.~~6. Medical necessity/medical judgment

~~iv.~~ii. Documentation will be maintained evidencing the use of providers involved in the development and or adoption of specific criteria utilized by the UM program.

~~v.~~iii. Criteria are applied in conjunction with considering individual needs, such as:

~~2.~~1. Age
~~3.~~2. Co-morbidities
~~4.~~3. Complications
~~5.~~4. Progress of Treatment
~~6.~~5. Psychosocial situations, and
~~7.~~6. Home environment

~~k.~~h. The Alliance and its delegates shall communicate to health care practitioners the procedures and services that require prior authorization, concurrent review or retrospective review and ensure that contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

i. The Alliance will ensure the integration of UM activities into the Quality Improvement System, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modification to the appropriate QI staff.

~~l.~~

VI. The Alliance and its delegates will ensure medical necessity determinations of mental health and substance use disorders services use current generally accepted standards of mental health and substance use disorder care and rules of conduct for Plan medical personnel by the following:

a. Medical decisions are rendered by qualified medical personnel and that only a qualified actively licensed health care practitioner with an active, unrestricted California license or, in the case of behavioral health decisions, a California Department of Health Care Services approved qualified licensed behavioral practitioner.
b. Decisions to modify, deny or authorize an amount, duration or scope of a service that is less than what was requested will be made by a qualified health care professional with appropriate clinical expertise or who is competent to evaluate the specific clinical issues using appropriate clinical guidelines in

treating the condition or disease. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.

c. Qualified health professionals supervise medical necessity review processes and documentation as described in Section II in the procedure section of this policy and procedure.
d. Qualified physicians and pharmacists with unrestricted licenses oversee UM decisions and sign all denials that are made, whole or in part, based on medical necessity.

VII. Personnel Responsible for each level and type of UM Decision Making

a. Medical Healthcare UM Decisions

UM Personnel	Responsibilities
UM/BH Coordinator	• Administrative Decisions: Qualified non-clinical staff may make non-medical necessity decisions for non-eligibility. • Receives and initially processes authorization requests to include eligibility and benefit verification. • Approves services using criteria included in the UM scope of practice. • Forwards all other requests to the UM/BH Reviewer or Medical Director/Doctoral Behavioral Health Practitioner, as appropriate. • Collects clinical information pertinent to the authorization request as directed by the UM/BH Reviewer/Medical Director/Doctoral Behavioral Health Practitioner. • Sends Notice of Action (NOA) letters when UM decision to approve, modify or deny a service has been rendered.
UM Reviewer/ BH Reviewer	• Hold a current unrestricted California Nursing or Behavioral Health License. • Review authorization requests processed by the Coordinators under their scope of practice. • Use evidence-based criteria or clinical guidelines to review and approve authorization requests.

UM Personnel	Responsibilities
	• May make non-medical necessity benefit denial decisions. • Forward to the Medical Director/designee/Doctoral Behavioral Health Practitioner authorization requests that require physician medical necessity review and/or are potential denials or modifications

Medical Directors / Doctoral Behavioral Health Practitioner	• The Chief Medical Officer (CMO) is board certified and holds a current unrestricted California License. • The Associate Medical Director / Doctoral Behavioral Health Practitioner holds a current unrestricted California license. • Use evidence-based criteria or clinical guidelines to review and approve, modify, or deny authorization requests. • Consult resources/guidelines available from appropriate national specialty professional boards or associations. • Identify cases with potential conflicts of interest sent for review and refer the cases to another Medical Director/Doctoral Behavioral Health Practitioner or the external reviewer for medical necessity review for a decision.

b. Supervision
   i. The Board of Governors delegates oversight of Utilization Management functions to the CMO and the Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC,)
   ii. A Medical Director/Doctoral Behavioral Health Practitioner must review any authorization request that may result in a denial due to medical necessity.
   iii. The Supervisor of Utilization Management provides day to day supervision of the UM Coordinator and UM Nurse staff:
      1. The Manager of Utilization Management provides oversight and day to day supervision of any Licensed Vocational Nurse (LVN) functioning in the department, ensuring that LVNs do not make medical necessity decisions.
      2. Consistently available to staff, either in on site or by telephone
      3. Ensures consistent criteria application, e.g., Inter-Rater Reliability testing.
      4. Provides staff training as needed.
      5. Monitors documentation adequacy.

c. Behavioral Health Care UM Decisions
   i. For Medi-Cal Specialty Mental Health (SMHS) and substance useservices for Medi-Cal Members are managed and delivered by Alameda County Behavioral Health Care Services (ACBHCS) providers. Mild to Moderate mental/behavioral healthcare services for Medi-Cal Members are delivered through the AAH Behavioral Health department.
   ii. Behavioral healthcare services for the Group Care and line of business is delivered through the Behavioral Health department.
   iii. Inpatient medical necessity non-coverage decisions may only be made by a behavioral health clinical peer reviewer.
      1. Board certified clinical psychiatrist or a psychologist with a current unrestricted license.

iv. Outpatient medical necessity non-coverage decisions may only be made by a behavioral health clinical peer reviewer (as described above) or a doctoral level clinical psychologist who has:
    1. Competency to review the case within their scope of practice.
    2. Current unrestricted California license.
v. AAH collects utilization management statistics, on at least a quarterly basis, to assess potential areas of under- or over-utilization of services.
    1. These data are reviewed by the Utilization Management Committee (UMC), which oversees the process for appropriate utilization of services.
    2. Findings are reported at the~~both UMC and~~ QIHE/UMC meetings to ensure quality oversight of utilization activities.
    3. Detailed analysis may be conducted to determine root cause of identified trends.
    4. Interventions are developed and approved at ~~UMC and~~the QIHE/UMC~~C~~ and are carried out by AAH, including collaboration with ACHBCS as indicated.

d. Pharmacy Prior Authorization/UM Decisions: See policy RX-002 Prior Authorization Review Process.
e. All decisions, including those for appeals, are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. In addition, all decisions are clearly documented.
f. Mechanisms to detect both under and over utilization of healthcare services including by delegated entities and include encounter and internal reporting mechanism to detect member utilization patterns.

VIII. The Alliance and its UM maintains current policies and procedures covering UM activities for all health services including behavioral health and substance use disorders as may be required by regulations, and contract including:
a. There is no difference in limitations on services, including Non-Quantitative Treatment Limitations (NQTLs) between Medical Surgical, Behavioral Health and Substance Use Disorder, ensuring parity in medical and behavioral service processes and practices.
b. UM or utilization review policies and procedures are available to Members and Providers upon request at no cost.

IX. The Alliance shall monitor and evaluate the care and services provided to Alliance members by delegates to ensure consistency with State and Federal regulations and NCQA standards.

X. The Alliance processes requests for a service/care that has already been rendered by the provider as retrospective reviews:
a. **Prior Authorization Review:** Submissions received prior to the Date of Service will be reviewed for medical necessity.
b. **Retrospective Authorization Review**: Submissions received up to 90 days from the date of service will be reviewed for medical necessity.

~~b.~~

~~b.~~ **Post-Retrospective Authorization Review:** Submissions received more than 90 days from the date of service will be reviewed for late submission exceptions prior to reviewing for a denial for not obtaining prior authorization. **Post-Stabilization Review following an Emergency Department admission:** Non-notification in accordance with the Alliance's notification policy and applicable law may result in an administrative denial. ~~.~~

~~iii.~~i. If retrospective services are administratively denied by the Alliance because of not requesting a prior authorization for services that require pre-approval or for non- notification for post-stabilization services, a NOA will be sent with appeal rights.

~~iv.~~ii. The provider may appeal through the appropriate medical necessity or provider payment dispute appeal process. If the provider believes that the exceptions were met for medical necessity review, they may submit medical records for review. The Alliance will review for medical necessity on appeal if the medical records show evidence that the exceptions were met.

c. Exceptions for retrospective requests for non-emergent or non-urgent services that would require prior authorization that are more than 90 days past the date of service may include member eligibility issues (i.e. retrospective eligibility, unable to validate eligibility at time of service, and incorrect eligibility information at the time of service. (UM-057).

XI. In the event of a Presidential or Gubernatorial emergency or major disaster declaration or an announcement of public health emergency by the secretary of HHS requirements for authorization/pre- notification will be waived as directed by DHCS.

PROCEDURE

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l. The Alliance maintains a full-time physician as medical director, with an active, unrestricted California license, whose responsibilities include, but are not limited to:
   a. Ensuring that:
      i. Medical care provided meets the standard for acceptable medical care.
      ii. Medical protocols and rules of conduct for plan medical personnel are followed.
   b. The Alliance and its delegates will ensure that medical decisions:
      i. Are rendered by qualified medical personnel and
      ii. Including those by delegated entities and rendering Providers, are not unduly influenced by fiscal and administrative management.
      iii. To deny, modify, delay, or terminate are reviewed by a qualified physician with an active, unrestricted California license (or in the case of behavioral health care decisions, a California Department of Health Care Services approved qualified license non-physician doctoral level psychologist)
   c. Developing and implementing the Utilization Management program and medical policy

d. Active participation in the function of Alameda Alliance's grievance procedures and resolving Appeals clinical grievances related to medical quality of care.
e. Direct involvement in the implementation of Quality Improvement activities

2. The Alliance UM manages:
    a. Services that allow direct access (services exempt from prior authorization)
        i. Prior authorization shall not be applied to emergency services, family planning services, preventive services, basic prenatal care in-network, sexually transmitted disease services, HIV testing, COVID 19 vaccines or therapeutics, or biomarker testing for members with advanced cancer stage 3 or 4.
        ii. Direct access to contracted in-network obstetrics and gynecology specialties for obstetrical care and well woman exams.
        iii. Direct access to services that do not require prior authorization, including in network physician to physician referrals. Please see attachment D Prior Authorization Grid
    b. Services that require authorization
        i. Processes for processing prior authorization, concurrent, and retrospective requests for authorization, including determination of medical services include, but are not limited to:
            1. Prior authorization and referral management
            2. Inpatient concurrent review, discharge planning, and care management
            3. Retrospective requests
    c. In collaboration with the Case Management department, Continuity of Care processes for outpatient to inpatient case management and vice versa, including processes for specialty/comprehensive case management, targeted case management and Transitional Care Services

3. Information sources used to make determinations are based on benefit coverage and Medical Necessity.
        i. Criteria, based on sound clinical evidence, are used to make determinations for approval, deferral, modification, and denial of service request.
            1. Criteria are reviewed on an annual and as needed basis and updated as necessary.
            2. Criteria is made available to its Practitioners or Members upon request. Practitioners or Members may call or fax their request. Reviewer contact information is included in the practitioner and provider correspondence for each denial decision.
            3. Evaluation of the consistency with which the health care professional involved in Utilization Review apply the Criteria in

decision making is done through Inter-Rater Reliability testing, at least annually and upon hire

4. Member benefits are described in the Member's Evidence of Coverage

4. Timeliness of review decisions, are consistent with state, federal and Department of Managed Health Care (DMHC) regulations
5. Processes for review of experimental and investigational referrals are described in UM-007 New or Experimental Technology Review Process.
6. Processes for review of second opinion are described in UM- 005 Second Opinions and are at no cost to the Medi-Cal Member
7. Processes for written notifications of determination through a Notice of Action Letter (NOA) or an Integrated Organization Determination to Providers and Members, that includes information for Providers and Members to Appeal a determination, consistent with state, federal and DMHC regulations including the additional state requirements for Medi-Cal Members which can be found in UM- 054 Notice of Action
8. The Alliance UM department:
    - ~~8~~a. Takes into consideration available services in the local delivery system and their ability to meet the member's specific healthcare needs, when UM criteria are applied.
    - ~~a.~~b. Identifies individuals who may need or who are receiving services from out of plan Providers and/or programs to ensure coordinated service delivery and efficient and effective joint case management for services, and
    - ~~b.~~c. Facilitates care coordination and meet the mandatory interface with the state and community-based organizations/programs including but not limited to the following linked and carved-out programs:
        i. Specialty Mental Health
        ii. Alcohol and Substance Abuse Treatment Service
        iii. Services for Children with Special Health Care Needs
        iv. California Children Services (CCS)
        v. Services for Persons with Developmental Disabilities
        vi. Early Intervention Services
        vii. School Linked CHDP Services
        viii. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Home and Community Based Services Waiver Programs
        ix. Dental
        x. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)
        xi. Women, Infants, and Children (WIC) Supplemental Nutrition Program

9. The Alliance UM provides oversight of delegated entities' compliance with state and federal regulations and Alameda Alliance's delegated UM activities, which includes, but not limited to, annual, focused, and supplemental audits/file reviews, and other types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS / ACRONYMS

1. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions (example: not eligible with the Alliance).
2. **Appeal** means a formal request by a Member or Member Representative on behalf ofa Member about a Utilization Review decision to deny, modify, delay, or terminate health care services.
3. **Behavioral Healthcare Practitioner (BHP)** is a physician or other health professional who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse facility and is accredited, certified, or recognized by a board of practitioner as having special expertise in that clinical area of practice.
4. **Benefits Determination:** A denial of a requested service that is specifically excluded from a Member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.
5. **Conflict of Interest:** A conflict of interest is a set of circumstances that creates a risk that professional judgment or actions of a person regarding the primary interest might be unduly influenced by a secondary interest. The existence of a conflict of interest is not, in and of itself, evidence of wrongdoing. In fact, for many professionals, it is virtually impossible to avoid having conflicts of interest from time to time. But a conflict of interest can become an issue if not disclosed or if the individual tries and/or succeeds in influencing the outcome of a decision, for personal benefit.
6. **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.
7. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.
8. **Medical Necessity:** Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.
9. **Medically Necessary (Group Care Program):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most

appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. (See current EOC)

10. **Medically Necessary (Medi-Cal Program):** means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:
    - **a.** Consistent with nationally accepted standards of medical practice:
        - **i.** "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer• reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.
        - **ii.** For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
        - **iii.** For purposes of covered services for Medi-Cal Members, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and
        - **iv.** When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT Supplemental Services as defined in Title 22, 51340 and 51340.1. and the most recent APL.

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

12. **Medically Necessary Mental Health and Substance Use Disorders** means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

a. In accordance with the current generally accepted standards of mental health and substance use disorder care.

b. Clinically appropriate in terms of type, frequency, extent, site, and duration.

~~c.~~ Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

~~c.~~

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13. **Member** means any eligible beneficiary who has enrolled in the AAH and who has been assigned to or selected AAH.
14. **National Committee for Quality Assurance (NCQA**) is a non-profit organization committed to evaluating and public reporting on the quality of health plans and other health care entities.
15. **Non-Contracted Provider** is a provider of health care services who is not contractually affiliated with AAH.
16. **Over Utilization of Healthcare** is the provision of services that are not medically necessary, or the provision of services that are medically necessary, but either in excessive amounts or in a higher-level setting than is medically indicated.
17. **Post Service** is defined as utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.
18. **Prior Authorization**: A type of Organization Determination that occurs prior to services being rendered.
19. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.
    a. NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services, but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.
20. **Qualified Health Care Professional** is a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.
21. **Second Opinion** is an alternate medical opinion provided by a physician of like or greater expertise than the physician providing the initial opinion and where the second physician is considered to be reasonably independent from the first serves to evaluate and determine the medical necessity for any proposed or continued treatment or other treatment options for the member's condition.
22. **Under Utilization of Healthcare** means failure to provide appropriate or indicated services or provision of an inadequate quantity or lower level of services than required.

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

AFFECTED DEPARTMENTS/PARTIES

- All Departments

RELATED POLICIES AND PROCEDURES

CMP-600 Internal Audit

QI-101 Quality Improvement Program
UM-005 Second Opinions
UM-007 New and Experimental Technology Review Process
UM- D-007 New and Experimental Technology Review Process
UM-054 Notice of Action
UM-057 Authorization Request Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- Prior Authorization Grid

REVISION APPROVAL HISTORY

11/30/2006, 3/15/2007, 1/1/2008, 9/22/2008, 10/31/2008, 1/16/2009, 4/4/2011, 10/18/2011, 12/30/2011, 4/27/2012, 10/18/2012, 12/12/2012, 05/06/2013, 08/21/2013, 09/24/2013, 10/14/2013,12/16/2013, 3/13/2014, 5/01/2014, 7/14/2014, 8/6/2014, 8/18/2014, 9/2/2014, 12/1/2014, 10/07/2015, 10/15/2016, 12/15/2016, 12/20/2017, 01/04/2018, 11/15/2018, 7/18/2019, 1/16/2020, 1/21/2021, 5/20/2021, **6/28/2022**, **2/21/2023**, **6/20/2023**, **8/16/2024, 9/17/2025, 5/20/2026, 7/22/2026**

Blue = Material Updates

REFERENCES

1. DHCS Contract, Exhibit A, Attachments 5, 9, 13
2. Title 22, Section 51159
3. 28 CCR, §1300.51 (d)(I-6)
4. Health & Safety Code, Section 1367.01

5. 42 CFR 438.900(d)

~~5.~~6. NCQA UM 2: Clinical Criteria for UM Decisions Element A -Factor 3

MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
    b. The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
2. Internal Monitoring
    a. The Internal Audit (IA) Department conducts internal audits of the Alliance's Functional Areas in accordance with CMP-600 (Internal Audit). IA prioritizes audits based on assessed risk and leadership guidance
    b. The Utilization Management Department, on a routine basis, reviews:
        i. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Quarterly reports of authorizations and claims for non-network specialty referrals.
3. Inter-Rater Reliability - At least annually and upon hire, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria requiring at a 90% pass rate. The Alliance will immediately provide remediation if the passing threshold is not met. New staff require testing prior to conducting utilization reviews without supervision.

POLICY AND PROCEDURE

Policy Number	UM-003
Policy Name	Concurrent Review and Discharge Planning Process
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Health Care Services
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Administrative Oversight Committee Approval Date	~~05/20/2026~~TBD

POLICY STATEMENT

This policy addresses the provision of inpatient services provided in an acute and long-term care acute inpatient settings: medical/surgical or behavioral. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.

Admission Review: Admissions to the acute hospital / long-term care acute hospital (LTACH)/ inpatient behavioral, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Sub-acute facility (peds and adults), SNF, acute Rehabilitation facility, etc.) for elective or non-elective diagnostic or therapeutic reasons must meet the guidelines for admission, utilizing approved written criteria, whether or not the admission was prior approved.

Continuous Stay Review: Subsequent review for ongoing medical necessity. Continued stay, (timeframe dependent upon the diagnosis and the progress of the patient) review will be performed using written criteria for medical necessity/continuous care and must be met to be approved.

PROCEDURE

A. Admission Review

1. The Alliance will be contracted by Hospitals/ facilities via Admission/ Discharge/ Transfer (ADT) feed, faxed copy of the admission face sheet or may submit the Inpatient Authorization or Post Acute Authorization Form for any new admissions to the health plan within 24 hours of the admission.

a. Elective admissions will have a tracking number and pre-certification referral on file.
b. Emergent admissions will require new case creation.

2. All facilities, contracted and non-contracted, must notify the Alliance within 24 hours of a change in the level of care or discharge from facility.
    a. Upon request, facilities must submit clinical information to the Alliance UM Department by the end of the next business day from the time of the request.
    b. Notifications and clinical notes received outside of the above timeframes may result in a delay/ deferral, or denial of the authorization for service and payment.

3. All Hospital Admissions will be treated as Urgent/ Expedited and processed using the timeline based on the member's line of business.

4. Eligibility and member's delegate assignment will be verified.

5. Authorization number will be assigned by the datasystem.

6. The review process may include, but not be limited to, thefollowing:
    a. Chart review;
    b. Data collection;
    c. Application of evidenced based criteria to determine the medical necessity of admission
    d. Review of care plans; and/or
    e. Transition of care services (TCS), social determinants of health (SDOH), and discharge planning

7. Complex and/or catastrophic cases may be discussed with the Medical Director or Director of Utilization Management.

8. Upon admission, The Alliance Medical Director may consult with the admitting physician on questions of medical necessity.
    a. If the Medical Director/ designee, following that consultation, determines the hospitalization is inappropriate, an alternative plan will be discussed with the admitting physician and a patient discharge will be requested in alignment with UM-015 Emergency Services and Post Stabilization Services.
    b. Inpatient care will be continued until the treating physician is notified and agrees on an appropriate care plan per Section 1367.01(h)(3).
    c. Notifications will be made according to established regulatory requirements if the admission does not meet medical necessity criteria.
    d. Only a Medical Director/ designee or doctoral Behavioral Health Practitioner may make a decision to deny services when medical necessity criteria are not met.

B. Medical Concurrent Review

1. Concurrent review is performed applying written criteria to determine medical necessity on a daily basis or on the cadence indicated in the criteria guidelines or based on the member's clinical condition:
    a. Two (2) to five (5) days a week, as appropriate for medical care review.

b. Not more than two (2) days per week for mental health and substance use admissions.
c. The patient is followed through the continuum/ levels of care, until they have returned to the optimum level of functioning.
d. Inpatient stay days for recipients who no longer require acute hospital care and are awaiting placement in a nursing home or other subacute or post-acute care or next level of care, Utilization Management staff will continue to perform continued stay reviews. The minimum review frequency is every 1 week or when the member's condition changes, until the Member is safely transitioned to the next level of care. Standard Concurrent Review processes will be utilized, including physician review as needed. Notice of Action letters are sent to members and requesting providers for each concurrent review resulting in a denial of services and agreement will be reached with the treating provider in alignment with section 1367.01(h)(3). See UM Policy UM-052.

2. Concurrent review information is obtained either via telephonic review, review of Electronic Health Record, by the portal or by fax, by a UM Clinical Reviewer.
   a. Select Medical Groups/ IPAs are delegated to perform concurrent review of assigned members applying written criteria, at the appropriate clinical cadence while hospitalized.
   b. The health plan and Medical Group/ IPA UM Department coordinate with each other, as appropriate.

3. Documentation is entered in the plan's database:
   a. Member progress is documented in a clinical note in the plan's database.
   b. The review cycle is continued at the appropriate clinical cadence until discharge.
   c. Documentation includes the date, time, and condition upon patients' discharge.

4. Following review, if the Medical Director determines the patient does not meet the medical necessity criteria for the current level of care and could be safely discharged or transferred to a lower level of care:
   a. The Reviewer will assess if adequate discharge efforts were made by the current facility, and if there is evidence of an unsafe discharge plan in place for the member (see UM-052).
   b. Only a Medical Director or designee/doctoral Behavioral Health Practitioner may make a decision to deny services.
   c. Qualified Medical Directors or designees review all denials of continued acute and long-term acute care hospitals (LTACH), Subacute, ICF-DD, Skilled Nursing Facility, and acute Rehabilitation facilities, services throughout the members' hospital stays.

C. Notice of Action Letters

1. For admissions that do not meet ongoing medical necessity for initial admission or continued stay, Medi-Cal members and providers are sent a Notice of Action (NOA) letter, for the initial denial and at every subsequent review. See UM-054 Notice of Action and UM-057 Authorization Request, for details on decision notification content and appeal rights.
   a. All other lines of business – send standard denial NOA letter if coverage is being

discontinued.

2. The UM Staff responsible for letters will follow the Standard Review procedures which includes the requirement that members and providers are given a NOA letter with accurate information about the denied date(s) and the requesting providers.

3. UM Staff will generate NOAs in the UM Information System, TruCare, which is configured to display the correct dates and providers in the automated portion of the CDL/ NOA letters.

4. Prior to final issuing of CDL/ NOAs, UM staff will verify the dates, service request/ stay level on the NOA match the dates of the final determination.
   a. NOAs found with discrepancies are immediately brought to the attention of UM Management team for immediate intervention.

D. Discharge Planning for All Lines of Business

1. Discharge planning and transitions of care services (TCS) begins at the time of admission for unscheduled patient stays and prior to admission for elective inpatient stays and continues throughout the patient's stay. The patient's progress is evaluated in order to plan for a timely discharge to the appropriate level of care with any scheduled home care or equipment as applicable.
   a. The discharge plan will be coordinated with the attending physician, the member and/or family, the hospital staff, the identified TCS care manager and any appropriate home health agencies/ vendors (i.e., home health, DME vendors, infusion services, etc.) or transportation needs.
   b. The need for patient education will be assessed as part of the Discharge Planning process.
   c. Evaluation of the discharge plan is included in the concurrent review sessions between the UM Clinical Reviewer, the Medical Director and facility's discharge planning staff.
      1). The member will be evaluated for potential alternative care needs.
      2). The attending physician will be responsible for keeping the member and family informed of progress toward discharge or transition to an alternative level of care.
      3). Notification of transition to an alternative level of care:
         i). Medi-Cal members and providers are sent a Notice of Action (NOA) letter.
         ii). All other lines of business – send standard denial letter if coverage is being changed/discontinued.
   d. Based on the discharge plan, the UM Clinical Reviewer will verify benefits for services and provide contracted vendor information and issue an authorization number to the Hospital Case Manager, as appropriate.
   e. Non-clinical staff may administratively enter limited visit authorizations for Home Health follow-up when a Home Health order is in place and an accepting provider has been identified.
   f. The UM Clinical Reviewer will coordinate the notification of the appropriate vendor regarding the discharge plan, date of discharge, and provide the authorization number.

g. The UM Clinical Reviewer will apprise the appropriate TCS Care Manager, of the discharge for the purpose of scheduling follow-up care, as needed.
h. For discharge to a lower level of care facility:
    1). The discharge plan will be coordinated with the attending physician, the member and/or family member or designated decision maker, and the hospital interdisciplinary staff. Evaluation of the discharge plan is included in the concurrent review process with the AAH UM Nurse/Reviewer, the facility discharge planning staff, the identified TCS Care Manager and the AAH Medical Director as indicated.
    2). The Alliance UM Nurse/Reviewer will verify benefits and provide the authorization decision to the hospital for appropriate placement.
        i). When significant barriers to placement exist, the Alliance UM Nurse/Reviewer will assist the facility in locating accepting facilities capable of managing the members' care needs.
            - The AAH UM staff will assist in contacting potential accepting facilities.
            - The AAH UM staff will initiate the Letter of Agreement (LOA) process for Out of Network (OON) facilities that would accept the member for care. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member. The procedure for discharge to the out of network facility will be coordinated with the OON facility and agreed upon before the discharge to ensure that the Member's needs are met during and after the transition. The option to create an ongoing contract with the OON facility will be offered.
            - The case will be discussed at Extended Length of Stay Rounds to identify placement options.
            - If LOS is prolonged, the AAH UM staff will escalate the case to AAH clinical and operational leadership to develop strategies to locate appropriate placement. See UM-052
                - Strategies to locate placement may include working administratively with facilities to develop capacity to manage the member's needs, contacting DHCS to assist in problem resolution, and/or identify contractual opportunities regarding placement.

E. Discharge Planning and Care Coordination, including for SPD Members

1. Discharge planning covers the period from admission to a hospital or institution and continues into the post-discharge period and ensures:
    a. Necessary care, services and supports are in place in the community after discharge.
    b. Outpatient appointments and/or follow-up visits with the member and/or caregiver are scheduled.
    c. Placement in lower level of care facilities is a coordinated transition of care.
    d. All discharge planning applies to in-network providers/ facilities or out of network

(OON) providers/ facilities if needed to meet the needs of the members.

e. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member.

2. Discharge planning is:
   a. Conducted through collaboration between the hospital/institution discharge planning staff and the Alliance UM Clinical Reviewer and the identified TCS Care Manager.
   b. Based on the DHCS PHM Policy Guide the MCP must have oversight of the Hospital's discharge planning process to ensure they assess, at minimum, a member's risk of:
      1). Re-institutionalization,
      2). Re-hospitalization,
      3). Destabilization of a mental health condition,
      4). And/or SUD relapse.
   c. Documented in both the hospital's patient medical record and/or theAlliance's member database and includes the following elements:
      1). Pre-admission status, including living arrangements, physical and mental function, social support, DME, and other services received.
      2). Pre-discharge factors including an understanding of the medical condition by the member/representative as applicable, physical and mental function, financial resources, and other social determinants of health, and social supports.
      3). Services needed after discharge to include:
         i). Type of placement preferred and agreed to bythe member/ family representative or designated decision maker.
         ii). Specific agency/ home recommended by the hospital and agreed to by the member/representative or designated decision maker.
         iii). Eligibility for ongoing care management services such as ECM, Complex CM, or other community case management services.
         iv). Recommended pre-discharge counseling.

      4). Summary of the nature and outcome of:
         i). Member/ representative or designated decision maker, involvement in the discharge planning process
         ii). Anticipated problems in implementing post-dischargeplans
         iii). Further action contemplated by thehospital/institution.

F. Behavioral Health Concurrent Review Process

1. Concurrent review is conducted for mental health and substance use disorder inpatient admissions. For behavioral health care, concurrent reviews for inpatients occur no more than every three (3) days. For residential treatment, reviews occur monthly.

2. Medical necessity determinations for Group Care members are based on non-profit professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), World Professional Association for Transgender Health (WPATH), Counsel of Autism Services Providers, American Psychiatric Association, and the American Psychological Association.

3. Concurrent review processes for behavioral health follow the same information gathering, documentation, medical review and notice of action (NOA) processes as described in this policy for medical services.

G. **Inpatient Behavioral Health Discharge Planning Coordination**

1. The discharge plan is reviewed for appropriateness, based on the individual's needs, and may include the following:
2. The discharge plan is realistic, comprehensive, timely and concrete;
3. The plan takes into consideration the AAH BH Clinician's recommendations and member's preferences, as recorded in previous treatment review notes;
4. Transition from one level of care or program to another is coordinated, and involves coordination with ACBHCS for Medi-Cal members with SMI/SUD;
5. AAH incorporates actions to assure continuity of existing therapeutic relationships, as appropriate;
6. The provider assists the member, parent, or guardian to understand the status of the discharge plan and has a signed copy;
7. Transportation and other needs are addressed as applicable;
8. The discharge plan is communicated to the aftercare provider(s) as applicable and with the member's permission;
9. Psychopharmacological needs are addressed;
10. Medical condition(s) follow-up needs are addressed.
11. Collaboration with medical practitioner has occurred, as necessary;
12. The member has timely access to the recommended aftercare services including date of first appointment, with whom, where, and other treatment and community resources to be utilized;
13. Barriers to aftercare planning are addressed and need for outreach or treatment reminders are indicated;
14. Support systems are outlined;
15. Community services and/or self-help groups are recommended;
16. Linkages to EAP services are established as appropriate;
17. Family/Work/Community preparation has occurred which supports reintegration as

appropriate.

18. Review of all ongoing and new in-network continuing care services (both covered and non-covered) to assist the provider/facility in identifying appropriate resources for discharge planning.

H. Coordination with Behavioral Health

1. Admissions related to behavioral health conditions are managed by the behavioral health staff and in compliance with the regulatory requirements and most recent DHCS All Plan Letter related to Medi-Cal Managed Care Health Plan Responsibilities for Mental Health Services.

2. Behavioral health admissions are co-managed when necessary to ensure the collaboration of medical and behavioral health services. AAH will facilitate access to necessary medical information and services for transition or discharge planning.

3. Members identified with need for medical case management services will be referred as defined in CM policy.

I. Transitional Care Services

1. The UM Clinical Reviewer will make referrals to Case/Disease Management and/or the Behavioral Health staff as appropriate, to provide Transitional Care Services at the beginning of the stay to ensure that a safe and appropriate transition plan is enacted for the member.
   a. Transitional Care Services (TCS) includes:
      - Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility to facilitate the participation of the Care Manager with the discharge planning and follow up.
      - Discharge Risk Assessment
        - Based on the DHCS PHM Policy Guide the MCP must have oversight of the Hospital's discharge planning process to ensure they assess, at minimum, a member's risk of:
          - re-institutionalization,
          - re-hospitalization,
          - destabilization of a mental health condition,
          - and/or SUD relapse.
      - Discharge Planning document.
      - A full description of the Alliance TCS program is found in CM-034 Transition of Care policy.

2. The member's needs are identified based on the following:
   a. Social environment
   b. Support structure through family and friends
   c. Availability and accessibility of needed services
   d. General Safety
   e. Complete care of the member on a continuum, including mental health and

substance abuse services.

J. Post- Acute care Admission to Hospice:

1. Hospice services will be provided to any member who receives a physician's certification that the member has a terminal illness and who elects hospice services.

2. Covered hospice services will be made available in a timely manner, preferably within 24 hours of the request.

3. Only general inpatient hospice services are subject to prior authorization (PA). PA is not a Medi-Cal requirement for routine home care, continuous home care, or hospice respite care.

4. The following settings are considered appropriate for post-acute care admission into Hospice:
    a. The member's home;
    b. A distinct part of a hospital psychiatric or rehabilitation unit;
    c. A home-based community setting; or
    d. A transition into the home.

K. Admission to Out of Network (OON) or Out of Area Facilities

1. Emergency admission to an OON or Out of Area facility will be followed by the UM or Behavioral Health (BH) Department. The UM/BH Clinical Reviewer will follow the member, utilizing the above guidelines, until the member is able to be safely transferred back into the appropriate network. The LOA process will be enacted for the Out of Network facility as needed or invited to contract with AAH.

2. The UM/BH Department will collaborate on a plan of care for a member who is being prior-authorized for out-of-area/network care. This includes referral to the TCS program to ensure that the safe and appropriate discharge plan and follow up care is enacted. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member.

3. The Member Services department will be notified if it appears that the member has moved permanently out of the area.

L. Delegation Oversight

1. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS AND ACRONYMS

Concurrent request – A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

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

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

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AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

BH-001 Behavioral Health Services
CM-001 Complex Case Management Identification, Screening Assessment and Triage
CMP-400 Delegation Oversight
UM-001 Utilization Management Program UM-051 Timeliness of UM Decision Making
UM-052 Discharge Planning to Lower Level of Care, Including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days
UM-054 Notice of Action
UM-057 Authorization Request UM-060 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION APPROVAL HISTORY

11/21/2006, 1/1/2008, 1/16/2009, 4/13/2011, 9/7/2012, 7/13/2013, 3/14/2014, 12/9/2016, 12/15/2016, 4/12/2018, 04/15/2019, 09/19/2019, 1/21/2021, 5/20/2021, 6/28/2022, **02/21/2023, 6/20/2023, 9/19/2023, 7/17/2024, 12/18/2024**, **5/20/2026, 7/15/2026**

Blue = material updates

REFERENCES

1. Section 1367.01(h)(3).
2. 45 CFR §146.136 Mental Health Parity and Addiction Equity Act
3. DHCS Contract, Exhibit A, Attachment 5, Provisions 2 and 3
4. DHCS PHM Policy Guide May 2024
5. DHCS PHM FAQ June 2024
6. NCQA UM Factor 1-A
7. Title 42, CFR, Sections 422.118 and 422.620

MONITORING

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

POLICY AND PROCEDURE

Policy Number	UM-004
Policy Name	Over- and Underutilization
Department Name	Health Care Services
Department Officer	Chief Medical Director
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	01/01/2008
Administrative Oversight Committee Approval Date	TBD

~~**Policy Number**~~	~~UM-004~~
~~**Policy Name**~~	~~Over and Under Utilization~~
~~**Department Name**~~	~~Health Care Services~~
~~**Department Officer**~~	~~Chief Medical Director~~
~~**Policy Owner**~~	~~Director Utilization Management~~
~~**Lines of Business**~~	~~MCAL, IHSS, DSNP~~
~~**Effective Date**~~	~~01/01/2008~~
~~**Administrative Oversight Committee Approval Date**~~	~~9/17/2025~~

Purpose:

To establish a systematic approach for identifying, monitoring and addressing patterns of healthcare over- and ~~underutilization~~underutilization to ensure appropriate allocation of healthcare resources, improve quality of care and promote cost-effectiveness while meeting members' healthcare needs.

Scope:

This policy applies to all clinical and non-clinical staff involved in utilization management activities, including but not limited to utilization review nurses, physicians, medical directors, quality improvement specialists and network management.

POLICY

~~1.~~A. Alameda Alliance maintains processes and mechanisms to monitor, detect, and correct Over- and ~~/U~~Uunder-~~U~~utilization of Medi-Cal, ~~and G~~Group Care and D-SNP services to ensure appropriate access, quality, and appropriateness of care.

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~~2.~~B. The over- and under-utilization review process is a component of the UM Program Evaluation and Work Plan.

~~3.~~C. Over- and u~~/U~~nderu~~ U~~tilization Monitoring/Detection/Correction processes shall include, but are not limited to:

~~a.~~1. Review of services for appropriate and cost-effective patient care for detecting and ~~/~~correcting over- and under-utilization.

~~b.~~2. Review for inappropriate utilization and/or care provided in an inappropriate setting(s) that may be indicative of barriers to health care services.

~~c.~~3. Monitoring over- and under-utilization for selected activities using UM measures to identify potential patterns and trends.

~~4.~~D. The Quality Improvement Health Equity/Utilization Management Committee (QIHE/UMC) is responsible for the review and analysis of network trend reports to identify potential areas of ~~under- and~~ over- and underutilization of services. These reports include, but are not limited to:

~~a.~~1. Ambulatory services (e.g., primary care visits, specialist services, preventive health care services and emergency room visits,)

~~b.~~2. Acute hospitalization (e.g., bed days, average length of stay and discharges, readmission rates within 30 days)

~~c.~~3. Out of network activities (e.g., specialist services, behavioral health care)

~~d.~~4. Behavioral health utilization data

~~e.~~5. Pharmacy utilization (e.g., antibiotics, emergency service usage, opioid use, medication management, etc. CMS star rating for prescription adherence)

~~f.~~6. Denied services and appeals

~~g.~~7. HEDIS use of service metrics.

E. The QIHE/UMC is responsible for identifying and adopting available industry benchmarks to measure network performance.

~~5.~~

~~6.~~F. The QIHE/UMC is responsible for developing and monitoring corrective action plans developed to address noted deficiencies.

~~7. For Alameda Alliance Wellness D-SNP, a dedicated Utilization Management Committee (UMC) has been established. This stand-alone committee is specifically designed to oversee and manage utilization review processes for the D-SNP program.~~

~~8.~~G. Reports will be presented to the ~~UM Sub-Committee and Quality Improvement Health Equity Committee (~~QIHE/UMC~~)~~ for review, comment, and consideration of utilization control strategies.

~~9.~~H. The internal reporting mechanisms used to detect member utilization patterns shall be reported to the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid (CMS) upon request.

I. The Compliance and Utilization Management Department are responsible for the review and annual update to policies for compliance with regulatory and contractual requirements.

~~10.~~

~~a.~~J. All policies will be presented and approved by the QIHE/UMC~~UM Sub-Committee and~~

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~~Quality Improvement Health Equity Committee~~.

PROCEDURE

A. Reports are generated from data from various resources including:
   a. Authorization data systems
   b. Claims and payments.
   c. Encounter data
   d. Medical records

~~2.~~B. The data is compared to available sources of comparable data and benchmarks that are external to Alameda Alliance including:
   a. Internally developed performance measures e.g., Admits per 1000, Bed-days per 1,000, ER Visits per 1000.
   b. DHCS-established Minimum Performance Levels (MPLs) and High-Performance Levels (HPLs).
   ~~b.~~c. National Medicaid HEDIS results for the 25th and 75th percentiles for measures related to over- and underutilization.
   ~~c.~~d. Previous year's network performance
   ~~d.~~e. CMS benchmarks for Medicare Advantage Plans
   ~~e.~~f. CMS Star Rating benchmarks
   ~~f.~~g. NCQA 75th percentile for industry standards
   ~~g.~~h. MCG criteria when applicable

~~B.~~C. Behavioral Health Department:
   ~~3.~~a. The Behavioral Health department collects utilization management statistics, on at least a quarterly basis, to assess potential areas of under- or over-utilization of services in accordance with CMS parity requirements for mental health and substance use disorder services.
   ~~a.~~b. Out of Network Behavioral Health Data is collected by Behavioral Health department and is submitted to The Alliance QIHE/UMC on a quarterly basis.
   c. ~~1.~~ This data is reviewed by the QIHE/UMC, which oversees the process for appropriate utilization of services
   d. ~~2.~~ Findings are reported at both the QIHE/UMC meetings because both quality and utilization components are included.
   e. ~~3.~~ Detailed analysis may be conducted to determine the root cause of an identified trend.
   f. ~~4.~~ Interventions are developed and approved by the QIHE/UMC and are carried out by assigned departments.

~~C.~~D. Delegation Oversite:
   a. Aggregation of all out of network data including Alameda Alliance and delegates per required CMS network adequacy standards.

~~D.~~E. Provider Oversite:
   ~~4.~~a. Alameda Alliance generates monthly reports to monitor the network performance with the established measures, which is reported at least quarterly.

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~~a.~~b. A statistical report is generated for outlier practitioners.
c. ~~1.~~ Practitioner Corrective Action Plan is developed as appropriate for outlier providers.
~~b.~~d. A statistical report of network adequacy is generated.
~~1.~~e. A referral to Provider Services is made when network adequacy problems are identified.
~~5.~~f. Data from the monthly analysis is submitted as part of the UM Work Plan to the QIHE/UMC for discussion and recommendations for addressing outlier results.
~~a.~~g. For the process of measuring potential underutilization of primary and preventive services in capitated setting, UM and Data Analytics collaborate to perform the following selected measures Out of Network specialty utilization.

DEFINITIONS

Utilization Management (UM): set of techniques used by or on behalf of healthcare providers and health plans to manage healthcare costs through case-by-case assessments of the appropriateness of care.
Over-utilization: The provision of services that exceed evidence-based guidelines, have limited or no clinical benefit, expose patients to risk that outweighs potential benefits.
Underutilization: Failure to provide medically necessary services or provision of an inadequate quality or lower level of services than is medically indicated.
CMS Star Rating: A quality rating system developed by CMS to measure the experiences members have with their health plans and healthcare systems.
Healthcare Effectiveness Data and Information Set (HEDIS): A tool used by health plans to measure performance on dimensions of care

AFFECTED DEPARTMENTS/PARTIES

Utilization Management, Quality Management, Health Care Analytics, Behavioral Health

RELATED POLICIES AND PROCEDURES

1. UM Program Description
2. UM-001 Utilization Management Program
3. UM-047 UM Sub-Committee
4. Quality Improvement Health Equity (QIHE) Program Description
5. QI-101 Quality Improvement Health Equity Program
6. QI-111 Delegation Management and Oversight
7. BH-001 Behavioral Health Services for Medi-Cal
8. BH-008 Behavioral Health Service for Group Care
9. BH-D-001 Behavioral Health Service for D-SNP

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

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REVISION HISTORY

1/1/2008, 10/28/2009, 8/24/2012, 4/4/2014, 1/10/2016, 12/15/2016, 10/12/2017, 5/3/2018, 7/19/2019, 3/18/2021, 3/22/2022, 6/20/2023, 7/17/2024, 9/17/2025, 5/27/2026

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REFERENCES

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1. 28 California Code of Regulations 28 CCR 1300.70(a)(l); 28 CCR 1300.70(b)(2)(G)(5); 1300.70(b) (H)(2)
2. DHCS Contract Exhibit A, Attachment 4, Section 9.B
3. 42 CFR 438.330 (b)(3)
4. 42 CRF 438.240 (b)(3)
5. 42 CRF 438.66
6. CMS Part C Reporting requirements

MONITORING

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The Utilization Management (UM) team monitors, tracks, and analyzes utilization statistics to detect over- and underutilization and reports its findings, with recommendations quarterly to the QIHE/UM in accordance with CMS quality improvement requirements. The QIHE/UMC will develop corrective action plans for UM team implementation, when appropriate, based upon that analysis following CMS Program Audit protocols and compliance requirements.

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

POLICY AND PROCEDURE

Policy Number	UM-005
Policy Name	Second Opinions
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	02/01/2000
Administrative Oversight Committee Approval Date	TBD~~9/17/2025~~

Purpose:

The Alliance will ensure patients have access to second opinions from qualified health care professionals within the Alliance's provider network for healthcare decisions. This policy establishes guidelines for requesting, processing and documenting second opinions to promote patient-centered care and informed decision-making.

Scope:

The policy applies to all healthcare providers, staff, and members of Alameda Alliance for Health (The Alliance).

POLICY STATEMENT

A. PCP (Primary Care Physician)/BH (Behavioral Health) Providers, Specialists, and Members (if the practitioner refuses), have the right to request a second opinion from a qualified health professional, at no cost to the Member from the Alliance, (Per 42 CFR section 438.206,) regarding proposed medical, surgical or behavioral health treatments from an appropriately qualified participating healthcare professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease condition, or conditions associated with the request for a second opinion.

B. Eligibility Criteria:

1. Questioning the reasonableness or necessity of recommended surgical procedures
2. Conditions threatening loss of life, limb, bodily function and substantial impairment of health
3. Unclear or complex clinical indications
4. Conflicting diagnostic test results

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5. Lack of improvement with current treatment plans
6. Concerns over diagnosis or plan of care

~~C.~~7. Second opinions from contracted providers do not require authorization and are arranged through the Member's assigned PCP or BH Provider.

~~D.~~8. When indicated, The Alliance provides for a second opinion from a qualified health care professional in network or arranges for the enrollee to obtain one out of network, at no cost to the enrollee.

~~E.~~9. A prior authorization from the Alliance is required to receive a second opinion from an out-of-network provider. The time frames for processing second opinions follow the standard authorization time frames.

~~F.~~10. The urgent second opinion authorization or a denial shall be provided in an expeditious manner appropriate to the nature of the member's condition, not to exceed 72 hours after the Alliance's receipt of the request.

PROCEDURE

A. Members should request a second opinion through their PCP, specialist, or BH Provider. If the PCP, specialist, or BH Provider refuses to submit a request for a second opinion, the Member can submit a grievance or a request for assistance through the Alliance Member Services.

B. Second opinions rendered by a contracted Alliance provider does not require prior authorization; the member's PCP, specialist, or BH Provider can coordinate the referral directly with a provider in the same of equivalent specialty to render the second opinion. Members can call the Alliance Member Services department to obtain assistance with this coordination.

C. Second opinions rendered by a non-contracted Alliance provider do require prior authorization. The PCP, specialist, or BH Provider submits the authorization request for a second opinion to the Alliance including documentation regarding the Member's condition and proposed treatment.

D. If the referral for a second opinion is approved, the Alliance assists with making arrangements for the Member to see a physician/BH Provider in the appropriate specialty.

E. If the referral for an ~~out of network~~out-of-network second opinion is denied or modified, the Alliance provides written notification to the Member including rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision.

F. The Alliance must consider the ability of the Member to travel to the second opinion practitioner's office, and if necessary, arrange transportation for the Member.

G. If there is no physician within the Alliance network that meets the qualifications for a second opinion, the Alliance must authorize a second opinion by a qualified physician or BH Provider outside the Alliance network.

H. Members disagreeing with an Alliance or Delegated Medical Group (DMG) denial of a second opinion may appeal through the Alliance appeal process.

I. In situations where the Member believes that the need for a second opinion is urgent, they can request facilitation by the Alliance by contacting the Alliance Member

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Services Department.

J. Reasons for providing or authorizing a second opinion include, but are not limited, to the following:

1. The Member questions the reasonableness or necessity of recommended surgical procedures;
2. The Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including, but not limited to a serious chronic condition;
3. Clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/specialist/BH Provider is unable to diagnose the condition and the Member requests an additional diagnostic opinion;
3.
4. The treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; and
5. The Member has attempted to follow the plan of care or consulted with the initial physician/BH Provider regarding serious concerns about the diagnosis or plan of care.

K. If the Member is requesting a second opinion about care from his or her PCP/BH Provider, the second opinion must be provided by an appropriately qualified physician/BH Provider.

L. If the Member is requesting a second opinion about care from a specialist, the second opinion must be provided by any physician of the same or equivalent specialty of the Member's choice, within the Alliance.

M. The plan reserves the right to limit a member's choice of provider for the second opinion from within the network/contracted providers when there is a qualified professional available. The member shall be referred outside when there is not an available/ qualified professional available.

A. The request to the practitioner that is performing the second opinion must include the timeframe for completion of the consultation and the requirements to be included in the consultation report.

N.

1. 0. The second opinion practitioner is responsible for submitting consultation reports to the Member, requesting practitioner, and PCP/BH Provider, within three working days of the visit.

P. 2. If the second opinion is deemed urgent, the submission of the consultation report must be within 24 hours of the visit.

Q. 3. Mandated timeframes for decision including approval, denial, or modification of a request for a second opinion and subsequent notification to the Member and practitioner are as follows:

1. O. Prior Authorization for Non-Urgent Second Opinions with Out-of-Network Providers:

a. 1. The prior authorization process is initiated when the Member's physician requests a second opinion.

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b.2. The timeframes for completion and adjudication of the second opinion are as follows:

a. 1). Practitioners have two days from the determination that a second opinion is necessary to submit the referral.

2).b. The Alliance's decision to approve, modify, or deny must be made within 7 calendar5 working days of obtaining only the information reasonably necessary to make a determination.

c. If sufficient information is not available with the second opinion request, the Alliance contacts the requesting practitioner for the additional clinical information. The Alliance must annotate that additional information has been requested and must include the date of the request. A decision to approve, deny or defer must be made within the 14 calendar day timeframe.

3).d. 3) Practitioners must be initially notified within 24 hours of the decision by telephone or in writing. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of the person making the call.

4).e. The Alliance must notify both the Member and practitioner in writing of all decisions, within 7 calendar5 business days of the request orf 14 calendar days if requesting additional information.

2.P. Prior Authorization of Urgent Second Opinions with Out-of-Network Providers:

a.1. Practitioners must submit urgent requests for a second opinion the same day of the determination that the second opinion is necessary.

b.2. Decisions regarding prior authorization for urgent second opinions and notification of decisions to practitioners must be completed within 72 hours of the receipt of the request.

c.3. Practitioners are notified of the decision by telephone or in writing within 24 hours of the decision and not to exceed 72 hours of receipt of request. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

d.4. Notification must be made to the Member and practitioner, in writing, within 72 hours of receipt of the request. If verbal notification is given within 72 hours of receipt of request, written orelectronic notification must be given no later than three calendar days after the initial verbal notification.

e.5. Both the Member and practitioner must be notified of how to file an expedited review at the time they are notified of the denial.

3.Q. Inpatient Second Opinions:

a.1. Requests for second opinions for Members in an inpatient setting at the same facility do not require prior authorization.

b.2. A request for second opinions for Members in an inpatient setting at a different facility, which requires the members to be transferred, requires authorization. Practitioners must be initially notified within 24 hours of the decision by telephone. If the practitioner cannot be reached by telephone, a fax can be utilized. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

c.3. The practitioner must be notified of denials in writing within 24 hours of the

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receipt of the request. If verbal notification is given within 24 hours of request, then written/ electronic notification must be given no later than three calendar days after verbal notification.

~~d.~~4. In the event of a denial, Notification must be made to both the Member and practitioner on how to file an expedited review.

~~4.~~R. Expedited Review:

~~a.~~1. If the practitioner receives a denial for an urgent or inpatient second opinion request, the practitioner can request an expedited review by contacting the Alliance's Chief Medical Officer or Medical Director.

~~b.~~2. If the Member receives a denial for an urgent or inpatient second opinion request, the Member can request an expedited review by contacting the Alliance's Member Services Department.

~~B.~~ Timeframes for decisions and notifications of the decisions to the Member and the practitioner regarding the expedited review are as follows:

3.

~~1).~~ Decisions must be made within 72 hours of the initiation of the

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a. expedited review and both the Member and the practitioner must be notified within one day after the decision is made.

~~5.~~b. Written confirmation of the decision must be provided to the Member and the practitioner within two working days from notification of the decision if the decision was not previously made in writing.

~~Q.~~ Delegation Oversight

A. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-400~~019~~ Delegation Oversight.

DEFINITIONS / ACRONYMS

Second opinion: A medical opinion provided by a qualified healthcare professional other than the patient's initial provider regarding diagnosis, treatment options or medical necessity of a procedure or service.

In-network provider: A healthcare provider who has contracted with the Alliance
Out-of-network provider: A healthcare provider who has not contracted with the Alliance

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 UM Program
UM-057 Authorization Service Requests
BH-001 Behavioral Health Services Medi-Cal
CMP-400~~019~~ Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION APPROVAL HISTORY

2/27/2001, 1/1/2008, 10/28/2009, 9/15/2011, 6/14/2012, 7/14/2013, 1/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 7/17/2024, 9/17/2025, 05/27/2026

REFERENCES

California Health & Safety Code, Section 1383.15
42 CFR Section 438.206

MONITORING

The ~~Compliance,~~ Utilization Management and Behavioral Health Departments will review this policy annually for compliance with regulatory and ~~-~~contractual~~-~~ requirements. All policies will be brought to the Quality Improvement Health Equity/ Utilization Management (QIHE/UM) Committee.

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POLICY AND PROCEDURE

Policy Number	UM-007
Policy Name	New and/or Experimental Technology Review Process
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) has an established mechanism for reviewing new and/or experimental technology as well as a new application of existing technology. The intent of the evaluation of new developments in technology and new applications of existing technology is to ensure that Alliance members have equitable access to safe and effective care.

The Alliance reviews new technology and new application of existing technology for inclusion in plan benefits. This review encompasses the following:

- Medical and/ or Surgical procedures
- Behavioral healthcare procedures
- Clinical Trials
- Pharmaceuticals
- Devices

The Alliance's new technology evaluation process will include:

- The process and decision variables the plan uses to make determinations, including review of:
    - Member access to services
    - Utilization patterns
    - Patient safety
    - Provider consistency in scope of utilization requests
- A review of information from appropriate government regulatory bodies, including the

Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), and the Centers for Medicare and Medicaid Services (CMS).

- A review of information from published scientific evidence.
- Obtaining input from relevant specialists and professionals with expertise in the technology.
- The Alliance's coverage decisions will be based on an assessment of new technology and new applications of existing technology, or on a review of special cases.

PROCEDURE

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A. New and Experimental Technology Criteria Implementation Process

1. Review and assessment of new and/or experimental technology is the sole responsibility of Alameda Alliance for Health in concert with State and Federal regulatory requirements and is not delegated to any health care partner or Delegated Medical Group. The process is designed to recognize and evaluate advances in medical, surgical, pharmaceutical, and behavioral health care technologies and includes review of the following:
    a. Medical and Surgical procedures, including transplants
    b. Drugs and pharmaceuticals
    c. Behavioral healthcare procedures
    d. Diagnostic and screening tests
    e. Alternative therapies
    f. Medical devices/equipment
    g. Clinical interventions
    h. Clinical Trials

B. Annual Review

1. Formal medical policy review (including medical, behavioral health and pharmacy) is conducted once a year using a two-step process requiring input from the Alliance Health Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC).
    a. The first step in the process is to propose the technologies and changes to technologies to be evaluated
    b. The second step is the actual revision of existing, or creation of new, policies using special case reviews are conducted throughout the year which are then approved by the CMO in accordance with review processes and timelines. The information from both processes is used for benefit determinations and coverage decisions.

C. UM Medical Director providing a proposed list of services for consideration at QIHE/UMC to CMO

1. The UM Medical Director will provide the proposed list of services and technologies to the CMO along with a summary and rationale for why the services should be evaluated.

2. The CMO, and the appropriate Medical Directors will identify benefit topics for which coverage policy development is indicated, i.e. sufficient benefit guidance/criteria for new or experimental technology are lacking.

3. The Alliance uses appropriate industry resources to develop unbiased, evidenced-based assessments of the safety and efficacy of new, emerging, and controversial health technologies and evaluation of the impact of these technologies on healthcare quality, utilization, and cost.

4. The Alliance Pharmacy Department will evaluate all new drugs that come onto the market within 6 months.

D. Process for the QIHE/UMC preparation and proposal

1. In preparing for the policy review, the UM Medical Director will coordinate the collection of necessary information about new and/or experimental technology and new uses of existing technology for review by the CMO, who will then propose to the QIHE/UMC the subject areas to be evaluated:
2. The CMO will present the list to the QIHE/UMC for discussion and approval.

3. The CMO will obtain input from the (QIHE/UMC) and the Pharmacy and Therapeutics Committee (P&T) for specific subjects and recommendations for review of new and/or experimental technology that should be considered for benefit coverage policy development.

E. Process following QIHE/UMC Approval

1. Once the QIHE/UMC approves the list of subject areas, the Alliance UM Medical Director, Pharmacy Director, or Behavioral Health (BH) Director will develop coverage policies that support decisions about use of new technology and new application of existing technology.
    a. The UM Medical Director, with Medical Management Department staff (including pharmacy and behavioral health staff where relevant), will review all relevant research on the service, technology or procedure, from available resources.

F. Development of specific coverage policies

1. The UM Medical Director, Pharmacy Director and BH Director will develop an initial assessment for specific each new or experimental technology topic consisting of an evaluation of scientific evidence to form conclusions about the benefits/risks of a particular device, therapy, procedure, diagnostic test, or preventive strategy in relation to its potential clinical use for a defined group of individuals.

G. CMO Review and approval of draft coverage policies and final approval at QIHE/UMC

1. The CMO reviews the draft coverage policies that are developed and presents the review of new and/or experimental technology research findings to the QIHE/UMC (and P&T for applicable pharmaceutical technology) for discussion and decision.
2. The UM Medical Directors will draft the Coverage Policy Statement for CMO review and approval.

H. Policy Distribution to Providers

1. Following CMO approval, each Coverage Policy Statement will be made available to providers through:
    a. Announcement of policy publication and availability in the next scheduled Provider Bulletin
    b. Contacting the UM Department at to request policy copies
    c. Posting on Alliance website Provider Portal (when feature is available).

Delegation Oversight

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The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 Delegation Oversight.

DEFINITIONS / ACRONYMS

Experimental Service: According to Title 22, CCR, Section 51056.1, an experimental service is any drug, equipment, procedure, or service that is in the testing phase undergoing laboratory and/or animal studies prior to testing in humans.

a. **Investigational Service:** According to Title 22, CCR, Section 51056.1, an investigational service is any drug, equipment, procedure, or service for which laboratory and/or animal studies have been completed and for which human studies

are in progress but testing is not complete: The efficacy and safety of such services in human subjects is not yet established; and

b. The service is not in wide usage.

Technology Assessment - A process established to evaluate the appropriate use of new technologies, new applications of existing technologies and the organizational or supportive systems within which such care is delivered. Services, procedures, pharmacological treatments, and behavioral health procedures are reviewed.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 6/12/2012, 4/25/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 7/17/2024, 9/17/2025, 7/23/2026

REFERENCES

NCQA UM 10 Evaluation of New Technology
Title 42, CFR, Section 422.202(b)

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MONITORING

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

POLICY AND PROCEDURE

Policy Number	UM-008
Policy Name	Coordination of Care – California Children's Services (CCS)
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Administrative Oversight Committee Approval Date	~~12/17/2025~~TBD

POLICY STATEMENT

This Policy describes how Primary care providers (PCPs) and specialists are responsible for the early identification and referral of children with potentially eligible conditions to the California Children's Services (CCS) program, notifying Alameda Alliance's Utilization Management (UM) Unit of such referrals to ensure the delivery of medically necessary care throughout the referral process regardless of CCS eligibility status.

~~A. PCPs and specialists are responsible for:~~

~~1. Early identification and referral of children with potentially eligible conditions to the California Children's Services (CCS) program.~~

~~2. Notifying Alameda Alliance's Utilization Management Unit of Members referred to CCS.~~

~~3. Administering medically necessary health care throughout the referral process, with the Alliance, regardless of whether or not the child is accepted into the CCS program. e.g., Medi-Cal for Kids & Teens, (formerly known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services for Medi-Cal Members.)~~

~~B. Alameda Alliance's Utilization Management Unit is responsible for:~~

~~1. Entering into a Memorandum of Understanding (MOU) with the Alameda County CCS Program.~~

~~2. Consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU.~~

~~Facilitating referrals and tracking outcomes.~~

~~3. Ensuring that plan providers:~~

~~. Are informed of the identity of CCS paneled providers and facilities.~~

a. Perform appropriate baseline assessments and diagnostic evaluations that provide sufficient clinical detail to establish or raise a reasonable suspicion that a member has a CCS eligible condition.

b. Refer potentially eligible children to the CCS program.

4. Ensuring that there is continuity of care between plan and CCS providers.

4. Submitting to the State required annual CCS reports on referrals accepted, denied, and pending with local CCS program by October 31st of each year.

4. Delivery of:

. All covered medically necessary health care and case management services for a member referred to CCS until CCS Program eligibility is established.

. Otherwise covered services not covered by the CCS program once eligibility is established.

. All other medically necessary covered services other than those provided through the Pediatric Palliative Care Program (PPC) for the CCS eligible condition once CCS eligibility is established.

4. In collaboration with CCS, assure coordination of services among the plan, the plan's primary care providers (PCP), the CCS specialty providers, and the CCS Program.

4. Maintenance of a CCS Liaison position in alignment with DHCS APL 23-014 who has received training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with the counties, care management and authorization processes.

4. Authorization of and payment of healthcare providers, including CCS paneled providers and approved facilities, for the delivery of medically necessary covered services that are unrelated to the member's CCS eligible condition

B. The CCS program is responsible for:

4. Diagnostic and treatment services for CCS eligible conditions.

4. Authorization of CCS paneled providers, Special Care Centers (SCCs) and approved facilities for the delivery of medically necessary covered services to treat the member's CCS eligible condition.

4. Covering Medi-Cal for Kids and Teens (EPSDT) Supplemental Services related to the CCS condition for Medi-Cal Members.

4. In collaboration with the plan, assure coordination of services among the plan's primary care providers (PCP), the CCS specialty providers, and the CCS Program.

4. Direct delivery of Physical Therapy (PT) and Occupational Therapy (OT) services for children eligible for the Medical Therapy Program (MTP)

PROCEDURE

A. Definition of California Children's Services

1. CCS Medical Eligibility criteria are outlined in Title 22, California Code of Regulation, Sections 41800-41872.
2. The CCS website also contains CCS Medical Eligibility criteria.

Alameda County CCS
1100 San Leandro Blvd., San Leandro CA 94577 Phone: (510) 208-5970 Fax: (510) 267-3254 http://dhs.ca.gov/pcfh/cms/ccs/

B. ~~Section I. Coordination of Care Process~~PCP and Specialists

1. Responsibilities:
   a. Early identification and referral of children with potentially eligible conditions to the California Children's Services (CCS) program.
   ~~a.~~b. Notifying Alameda Alliance's Utilization Management Unit of Members referred to CCS.
   ~~b.~~c. Administering medically necessary health care throughout the referral process, with the Alliance, regardless of whether or not the child is accepted into the CCS program. e.g., Medi-Cal for Kids & Teens, (formerly known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services for Medi-Cal Members.)
   ~~c.~~d. After enrollment into the CCS Program, the PCP continues to provide medically necessary care for the child in a comprehensive fashion, including delivery of appropriate services within their scope of practice, that are related to the CCS eligible condition and are provided in coordination with the CCS-authorized specialist of Special Care Center.

~~1.~~2. Identification and Referrals: ~~PCPs and specialists are responsible for early identification of Members that may have eligible CCS conditions.~~
   a. The identification can occur at any medical encounter including Well Child Visits, acute or chronic illness visits, and the Initial Health Assessment performed at a visit within 120-days of enrollment.

~~1. CCS Medical Eligibility criteria are outlined in Title 22, California Code of Regulation, Sections 41800-41872.~~
~~2. The CCS website also contains CCS Medical Eligibility criteria.~~

3. Documentation:
   ~~3.~~a. CCS referrals are documented in the Medical Record. Documentation must include:
   ~~a.~~b. Appropriate and timely referrals for actual and potential cases (within 24

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hours of identification of CCS case).

c. Periodic management of medically necessary health care throughout the course of CCS eligibility.

~~b.~~

C. Alameda Alliance

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1. Responsibilities:
   a. Entering into a Memorandum of Understanding (MOU) with the Alameda County CCS Program.
   b. Consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU.
   c. Ensuring that plan providers:
      i. Are informed of the identity of CCS paneled providers and facilities. Perform appropriate baseline assessments and diagnostic evaluations that provide sufficient clinical detail to establish or raise a reasonable suspicion that a member has a CCS eligible condition.
   d. Ensuring that there is continuity of care between plan and CCS providers.
   e. Maintenance of a CCS Liaison position in alignment with DHCS APL 23-014 who has received training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with the counties, care management and authorization processes.
   f. Authorization of and payment of healthcare providers, including CCS paneled providers and approved facilities, for the delivery of medically necessary covered services that are unrelated to the member's CCS eligible condition

2. Delivery of:
   a. All covered medically necessary health care and case management services for a member referred to CCS until CCS Program eligibility is established.
   b. All other medically necessary covered services other than those provided through the Pediatric Palliative Care Program (PPC) for the CCS eligible condition once CCS eligibility is established.
   c. In collaboration with CCS, assure coordination of services among the plan, the plan's primary care providers (PCP), the CCS specialty providers, and the CCS Program.

3. Identification and referrals:
   ~~B.~~a. Members with potential CCS conditions may also be identified in the following ways:
   ~~1.~~b. Alliance Utilization Management (UM) - identification can occur through review of specialty or diagnostic referrals that suggest a CCS condition.
   ~~2.~~c. Alliance Case Management (CM) - may directly identify potential CCS cases during discharge planning or other CM activities.
   ~~a.~~d. Monthly reporting from CCS of members attributed to the MCP with the CCS benefit and CCS eligible diagnoses, but may or may not have an open Service

Authorization Request (SAR)

~~2.~~4. Documentation:

a. Submitting to the State required annual CCS reports on referrals accepted, denied, and pending with local CCS program by October 31st of each year.

b. Tracking outcomes of referrals

c. The Alliance and the local CCS program exchange enrollment data on a monthly basis in order to facilitate coordination of care. The local CCS program provides the Alliance with a list of its members who have been accepted into the program

~~3.~~d. A link to the CCS Paneled Provider Directory is available for Alliance PCPs and Specialists on the Alliance Provider portal.

~~4.~~e. An article on the CCS Program is published annually in the Alliance Provider Bulletin.

~~5.~~f. The Alliance Provider Manual includes contact information for the county CCS offices.

5. Care Coordination:

~~C.~~a. Members not accepted into the CCS Program receive all medically necessary covered services through the Alliance and its contracted specialists.

~~D.~~b. The Alliance must assist the PCP in coordinating available services and providing follow- up for Members requiring referral to CCS through the following methods:

~~1.~~i. Maintenance of continuity of care through coordination with case managers from the CCS programs.

~~2.~~ii. Coordination with the PCP to ensure that medically necessary health care services are provided for conditions not eligible for the CCS program.

~~3.~~6. Age Out Process:

a. High-risk CCS Members (who are expected to have a chronic health condition that will extend past their 21st birthday) and are aging out of the CCS program will be identified by the AAH UM Team beginning at the age of 17

b. For all CCS eligible members beginning within the 12 months prior to their 21st birthday the UM team will complete an assessment of the transition needs and begin assisting the member in coordinating the transition back into the Alliance Network quarterly through a partnership with the Case Management Department. Quarterly check ins will include:

~~a.~~i. Identifying the Member's CCS-Eligible Condition

~~b.~~ii. Planning for the needs of the Member Transition from the CCS Program

~~c.~~iii. Communication plan with the Member in advance of the transition

~~d.~~iv. Identification and coordination of Primary Care and specialty care Providers appropriate to the Member's CCS Eligible Condition(s) and

~~i.~~v. Continued assessment of the member through the first 12 months of the transition. If member is found to have extensive care coordination needs,

a referral will be placed for the Complex Case Management team to assist member.

c. Alameda Alliance will complete the Assessment and quarterly check ins for Delegated members per the Delegation Agreements.

D. CCS Team

1. Responsibilities:

a. CCS provides diagnostic services, medical treatment, Case Management, and transition services to children with conditions eligible for treatment under the CCS program. PCPs, the Alliance's UM/CM program or referral specialists identify children with potential CCS eligible conditions.

~~3.~~b. Diagnosis and Treatment Program - Provides medically necessary care and Case Management to infants, children and adolescents meeting program eligibility requirements, complications of a CS eligible condition, or other conditions which complicate or interfere with the management of the CCS eligible condition. CCS may authorize diagnostic services necessary to confirm a suspected CCS eligible condition if the referring physician's medical records support a high probability of presence of the suspected CCS condition.

~~4.~~c. CCS Medical Therapy Program (MTP) - Provides medically necessary physical therapy, occupational therapy, equipment consultation, and durable medical equipment (DME) to children who are medically eligible for CCS. Please refer to the CCS MTP eligibility regulations at https://www.dhcs.ca.gov/servcies/ccs/Pages/medicaleligibility.aspx

~~5.~~d. High Risk Infant Follow-up Program (HRIF) - If eligible, provides follow-up for infants discharged from a Neonatal Intensive Care Unit (NICU) for up to age 3 who are at risk for developing a CCS eligible condition. These services include developmental testing, neurological, ophthalmologic, and audiological evaluations.

e. Transition Services – a transition specialist (social worker) leads the local CCS team in coordinating transition of care. Services are coordinated with Special Care Centers (SCC), pediatric and adult PCPs, families, DME vendors and family members. Multidisciplinary case conferences are held as needed to support transition planning.

f. Authorization of CCS paneled providers, Special Care Centers (SCCs) and approved facilities for the delivery of medically necessary covered services to treat the member's CCS eligible condition.

g. Covering Medi-Cal for Kids and Teens (EPSDT) Supplemental Services related to the CCS condition for Medi-Cal Members.

~~6.~~

2. Enrollment into CCS:

~~E.~~a. CCS accepts referral forms from individuals or entities. Therefore, PCPs, specialists or the Alliance are responsible for the completion of referral forms. Applicable medical records and a request for CCS services should be submitted to CCS.

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~~F.~~b. CCS sends a CCS program application and agreement to the Member, parent, or legal guardian. The PCP may assist with the completion of the forms. The Member, parent or legal guardian must sign the form in order to be eligible for benefits not covered by Medi-Cal.

~~a.~~c. CCS determines medical eligibility by evaluating medical records in order to determine whether the child has, or is likely to have, a CCS medically eligible condition.

~~G.~~d. Once CCS program eligibility is established and the request for service is approved, CCS issues an authorization for treatment and payment to a CCS approved practitioner, Special Care Center, or hospital. All services require prior authorization by CCS.

~~H.~~e. CCS is responsible for Case Management of CCS eligible conditions and will collaborate with the PCP as needed to accomplish this.

E. **Section II. Delegation Oversight**

1. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-400 Delegation Oversight.

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DEFINITIONS

California Children's Services (CCS) - A state-county partnership with blended federal/state/county funding which covers medically necessary care and case management services related to certain diagnoses for children birth to age 21 years of age. CCS services are delivered by paneled providers and approved tertiary care medical centers in local communities.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-002 – Coordination of Care
CM-043 Child Welfare Liaison
CMP-400 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008 10/28/2009, 8/18/2011, 3/4/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/20/2020, 3/22/2022, 6/20/2023, 7/17/2024, 12/17/2025, 5/26/2026

REFERENCES

1. DHCS APL 24-013 Managed Care Plan Child Welfare Liaison
2. DHCS Contract Exhibit A, Attachment 11. §9.
3. MRMIB Contract § A.IV.B.
4. Title 22, CCR, Section 41518.
5. DHCS Calendar Year 2025- C Amendment
6. DHCS June 2024 California Children's Services Program Transition of Care from Pediatric to Adult Health Care Frequently Asked Questions (FAQ)

MONITORING

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

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

POLICY AND PROCEDURE

Policy Number	UM-011
Policy Name	Coordination of Care - Hospice Services and Terminal Illness
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Administrative Oversight Committee Approval Date	TBD~~12/17/2025~~

POLICY STATEMENT

Purpose:
To establish a comprehensive, compassionate and regulatory-compliant approach to hospice and terminal illness care ensuring patient dignity, comfort and appropriate medical management.

Scope:
This policy applies to all healthcare professionals involved in the care of terminally ill members.

A.
Hospice

1. Hospice Care shall be limited to Members who have been certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.
2. A Member who elects to receive Hospice Care must file an election statement with the hospice providing the care. The election statement shall include:
    a. Identification of the hospice;
    b. The Member's or representative's acknowledgement that:
    c. There is a full understanding that the hospice care given as it relates to the member's terminal illness will be palliative rather than curative in nature.
    d. Certain specified Medi-Cal benefits are waived by the election.
    e. The effective date of the election;
    f. The signature of the Member or representative.
3. A Member's voluntary election may be revoked or modified at any time.

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4. The Member must file a signed statement with the hospice revoking the Member's election for the remainder of the election period;
5. A Member or representative may:
    a. Execute a new election for any remaining entitled election period at any time after revocation;
    b. Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.
6. If the member is residing in a Long-Term Care Facility
    a. Section 1905(o)(1)(A) of the SSA allows for the provision of hospice care while an individual is a resident of a nursing facility (NF) or Intermediate Care Facility for the Developmentally Delayed (ICF/DD). Payment will be provided to the hospice agency directly.
    b. The hospice will then reimburse the NF for the room and board at the rate negotiated between the hospice and the NF
    c. Dual eligible members the hospice shall notify the MCP when a member elects Medicare hospice benefit. The MCP will then pay the room and board payment to the hospice provider.
    d. Eligibility for nursing facility room and board will be determined by the MCP and the nursing facility.

B. Member Eligibility & Election of Hospice

1. Hospice services will be provided in a timely manner, preferably within 24 hours of request, to any member who receives a physician's certification that the member has a terminal illness and who then elects hospice services
2. Members who qualify for, and elect hospice remain enrolled in the Alliance while receiving these services.
3. The "election period" for hospice services consists of the following:
    a. An initial 90-day period;
    b. A subsequent 90-day period;
    c. An unlimited number of 60-day periods.
4. Members are informed of the availability of Hospice Care as a covered service and the methods by which they may elect to receive these services through their Combined Evidence of Coverage and Disclosure Forms (EOCs).
5. Hospice services provided for Alameda Alliance Wellness D-SNP are covered under traditional Medicare FFS. Alameda Alliance Wellness does not manage these services directly. Alameda Alliance Wellness D-SNP coordinates and facilitates transitions into hospice care to ensure members' needs are met during this period. Individualized Care Plans are updated to reflect the transition to hospice by the Care Management Team and the Interdisciplinary Care Team (ICT) is notified.

C. Authorization Requirements

1. The Alliance may require a Prior Authorization for General Inpatient Care for In-Network

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or Out of Network Providers.

a. The Alliance may require documentation, for reasons of justification, following the provision of general inpatient care.

i. The below documents must be submitted to the MCP for General Inpatient Care:

1. A written prescription signed by the Member's attending physician
2. Justification for the general inpatient level of care
3. A copy of the certification of the member's terminal condition
4. A copy of the written initial plan of care; and
5. A copy of the member's signed election form

2. The Alliance may require Prior Authorization for Out of Network Hospice levels of care including:

a. Routine home care

b. Continuous home care requiring a minimum of eight hours of care per 24-hour period

c. Respite care provided on an intermittent non-routine, and occasional cases for up to five consecutive days at a time

3. Authorization Guidelines

a. The Alliance uses written utilization review criteria based on sound medical evidence, consistently applied, regularly updated, and annually reviewed and approved by the Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC)

b. MCG (formerly Milliman Care Guidelines) Guidelines are licensed and approved for use as a primary reference in the medical necessity decision making process.

c. Other applicable publicly available guidelines from recognized medical authorities are referenced, when indicated.

d. National Coverage Determinations and Local Coverage Determinations are also utilized for D-SNP members

4. The Alliance's policies shall conform to the statutory definition of terminal illness: "Terminally ill means the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course."

5. Codes that require an authorization for In-Network providers can be found on the Prior Authorization Grid

6. All out of Network Providers require authorization for all levels of Hospice Care and are subject to potential re-direction to an In-network Provider so long as it does not impact or delay medically necessary care to the member.

a. Alliance Care Coordination/ Utilization Management is required to arrange for the continuity of medical care, including maintaining established Member-Provider relationships, to the greatest extent possible.

D. Covered Services

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1. Hospice services include, but are not limited to:
    a. Nursing services.
    b. Physical therapy, occupational therapy, or speech-language pathology.
    c. Medical social services under the direction of a physician.
    d. Home health aide and homemaker services.
    e. Medical supplies and appliances.
    f. Drugs and biologicals.
    g. Physician services including:
    h. General supervisory services of the hospice medical director
    i. Participation in the establishment of plans of care
    j. Supervision of care and services
    k. Periodic review and updating of Care Plans
    l. Establishment of governing policies
    m. Counseling services related to the adjustment of the member's approaching death; counseling, including bereavement, grief, dietary and spiritual counseling.
    n. Continuous home care services may be provided on a 24-hour basis only during periods of crisis and only as necessary to maintain the terminally ill member at home.
    o. A "period of crisis" is defined as a period in which a member requires continuous care for as much as 24 hours a day to achieve palliation and management of acute medical symptoms.
    p. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing, or hospice facility.
    q. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing, or hospice facility.
    r. Bereavement Services providing counseling to family members up to 12 months following the death of the member
    s. Any other palliative item or services for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.

2. Hospice Care is not considered Long-Term Care (LTC) regardless of the Member's expected or actual length of stay in a nursing facility.
    a. Members in Long-Term Care who elect the hospice benefit will not be disenrolled from the Alliance.

3. For Medi-Cal services not covered by a hospice provider include:
    a. Private pay room and board or residential care
    b. Acute in-patient hospitalization unrelated to the terminal illness
    c. Level A or B nursing facility (NF) for unrelated issues

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d. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.

e. Other necessary services for conditions unrelated to the terminal illness.

4. Alameda Alliance for Wellness D-SNP services not covered by FFS Medicare Hospice include:

a. Curative treatments

b. Non-Hospice provider care

c. Room and board

d. Emergency room visits unless coordinated by hospice for hospice related care

e. Ambulance transport not coordinated by hospice for hospice related care

f. Prescription drugs intended to cure the terminal illness

g. Experimental treatments

E. Pediatric Hospice

1. CCS clients with a certified life expectancy of 6 months or less, who have elected hospice care, and request continuing treatment of the condition on which their hospice eligibility is based, may continue to receive CCS medically necessary concurrent palliative and non-palliative services. See DHCS APL 18-020 Palliative Care

F. Payment and Billing

1. Hospices will bill the MCPs using the following revenue codes:

a. Revenue Code 0658- Facility Type Code 25

b. Revenue Code 0658- Facility Type Code 26

c. Revenue Code 0658- Facility Type Code 28

d. Revenue Code 0658- Facility Type Code 65

e. Revenue Code 0658- Facility Type Code 81

f. Revenue Code 0658- Facility Type Code 86

G. Timeliness & Access Standards

1. Hospices shall notify the MCP of general inpatient care placement that occurs after normal business hours on the next business day.

2. The hospice provider will notify the plan when a plan member residing in a nursing home paid by Medi-Cal elects the Medi-Cal hospice benefit.

H. Hospice Revocation

1. A Member's voluntary election may be revoked or modified at any time.

2. The Member must file a signed statement with the hospice revoking the Member's election for the remainder of the election period;

3. A Member or representative may:

a. Execute a new election for any remaining entitled election period at any time after revocation;

b. Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.

I. Member Rights (Grievance and Appeals)

1. Communication of Denial Determination

a. The Alliance shall provide the following information to the requesting provider and member written notification for denied requests related to a terminal illness within five (5) business days of a denial coverage for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider :

i. The denial Notice of Action (NOA)/ Coverage Determination Letter (CDL) includes:

1. statements about the specific medical and scientific reasons for denying coverage.

2. A description of the criteria or guidelines used

3. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine

4. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368

2. Grievance and Appeals Process

a. Upon receiving a complaint form requesting a conference pursuant to paragraph (3) of subdivision (a) of CA Health and Safety Code §1368.1 (b), the plan shall provide the enrollee, within 30 calendar days, an opportunity to attend a conference:

i. To review the information provided to the enrollee pursuant to paragraphs (1) and (2) of CA Health and Safety Code §1368.1 subdivision (a);

ii. Conducted by a plan representative having authority to determine the disposition of the complaint;

iii. The plan shall allow attendance, in person, at the conference, by an enrollee, a designee of the enrollee, or both, or, if the enrollee is a minor or incompetent, the parent, guardian, or conservator of the enrollee, as appropriate;

iv. However, the conference required by CA Health and Safety Code §1368.1 subdivision (a) shall be held within five business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice that the effectiveness of either the proposed treatment, services, or supplies

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or any alternative treatment, services, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date.

J. Monitoring and Oversight

1. Delegation Oversight

    a. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-400 for monitoring of delegation oversight.

2. Provider Oversight

    a. The Alliance maintains safeguards to validate member elections and prevent Fraud, Waste and Abuse through provider documentation audits.

~~A. Hospice services will be provided in a timely manner, preferably within 24 hours of request, to any member who receives a physician's certification that the member has a terminal illness and who then elects hospice services.~~
~~B. Members who qualify for, and elect hospice remain enrolled in the Alliance while receiving these services.~~
~~C. Hospice Care is not Long-Term Care (LTC) regardless of the Member's expected or actual length of stay in a nursing facility.~~
~~Members in Long-Term Care who elect the hospice benefit will not be disenrolled from the Alliance.~~
~~C. The "election period" for hospice services consists of the following: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of 60-day periods.~~
~~D. These services include, but are not limited to:~~
~~1. Nursing services.~~
~~1. Physical, occupational, or speech language pathology.~~
~~1. Medical social services under the direction of a physician.~~
~~1. Home health aide and homemaker services.~~
~~1. Medical supplies and appliances.~~
~~1. Drugs and biological.~~
~~1. Physician services~~

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2. Family counseling services related to the adjustment of the member's approaching death; counseling, including bereavement, grief, dietary and spiritual counseling.
3. Continuous nursing services may be provided on a 24-hour basis only during periods of crisis as necessary to maintain the terminally ill member at home.
Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing, or hospice facility.
4. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing, or hospice facility.
4. . Bereavement Services providing counseling to family members up to 12 months following the death of the member
4. Any other palliative item or services for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.
D. Prior Authorization may not be required for routine home care, continuous home care, respite care, or hospice physician services. The Alliance may require documentation, for reasons of justification, following the provision of general inpatient care.
D. Hospices shall notify the MCP of general inpatient care placement that occurs after normal business hours on the next business day.
D. Members are informed of the availability of Hospice Care as a covered service and the methods by which they may elect to receive these services through their Combined Evidence of Coverage and Disclosure Forms (EOCs).
D. The hospice provider will notify the plan when a plan member residing in a nursing home paid by Medi-Cal elects the Medi-Cal hospice benefit. See APL 13-014 for reimbursement guidelines.
D. Hospice services provided for Alameda Alliance Wellness D-SNP are covered under traditional Medicare FFS. Alameda Alliance Wellness does not manage these services directly. Alameda Alliance Wellness D-SNP coordinates and facilitates transitions into hospice care to ensure members' needs are met during this period. Individualized Care Plans are updated to reflect the transition to hospice by the Care Management Team and the Interdisciplinary Care Team (ICT) is notified.
D. For Medi-Cal services not covered by a hospice provider include:
4. Private pay room and board or residential care
4. Acute in-patient hospitalization unrelated to the terminal illness
4. Level A or B nursing facility (NF) for unrelated issues
4. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
4. Other necessary services for conditions unrelated to the terminal illness.
D. Alameda Alliance for Wellness D-SNP services not covered by FFS Medicare Hospice include:
4. Curative treatments
4. Non-Hospice provider care
4. Room and board
4. Emergency room visits unless coordinated by hospice for hospice related care
4. Ambulance transport not coordinated by hospice for hospice related care
4. Prescription drugs intended to cure the terminal illness
4. Experimental treatments
CCS clients with a certified life expectancy of 6 months or less, who have elected hospice care, and request continuing treatment of the condition on which their hospice eligibility is based, may continue to receive CCS medically necessary concurrent non-palliative services. See DHCS APL 18-020 Palliative Care
Terminal Illness

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~~The Alliance will comply with CA Health and Safety Code and Centers for Medicare and Medicaid (CMS) regulatory guidance when making service request decisions for enrollees who have been diagnosed with a terminal illness.~~

~~PROCEDURE~~

~~Hospice~~

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~~A. Hospice Care shall be limited to Members who have been certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.~~

~~B. A Member who elects to receive Hospice Care must file an election statement with the hospice providing the care. The election statement shall include:~~

~~1. Identification of the hospice;~~

~~The Member's or representative's acknowledgement that:~~

~~a. There is a full understanding that the hospice care given as it relates to the Member's terminal illness will be palliative rather than curative in nature.~~

~~a. Certain specified Medi-Cal benefits are waived by the election.~~

~~2. The effective date of the election;~~

~~2. The signature of the Member or representative.~~

~~B. A Member's voluntary election may be revoked or modified at any time.~~

~~2. The Member must file a signed statement with the hospice revoking the Member's election for the remainder of the election period;~~

~~2. A Member or representative may:~~

~~a. Execute a new election for any remaining entitled election period at any time after revocation;~~

~~a. Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.~~

~~B. Alliance Care Coordination/ Utilization Management is required to arrange for the continuity of medical care, including maintaining established Member-Provider relationships, to the greatest extent possible.~~

~~B. If the member is residing in a Long-Term Care Facility~~

~~2. Section 1905(o)(1)(A) of the SSA allows for the provision of hospice care while an individual is a resident of a nursing facility (NF) or Intermediate Care Facility for the Developmentally Delayed (ICF/DD). Payment will be provided to the hospice agency directly.~~

~~2. The hospice will then reimburse the NF for the room and board at the rate negotiated between the hospice and the NF~~

~~2. Dual eligible members the hospice shall notify the MCP when a member elects Medicare hospice benefit. The MCP will then pay the room and board payment to the hospice provider.~~

~~a. Eligibility for nursing facility room and board will be determined by the MCP and the nursing facility.~~

~~2. Hospices will bill the MCPs using the following revenue codes:~~

~~a. Revenue Code 0658- Facility Type Code 25~~

~~a. Revenue Code 0658- Facility Type Code 26~~

~~a. Revenue Code 0658- Facility Type Code 28~~

~~a. Revenue Code 0658- Facility Type Code 65~~

~~a. Revenue Code 0658- Facility Type Code 81~~

~~a. Revenue Code 0658- Facility Type Code 86~~

~~a.~~

~~**Terminal Illness**~~

~~A. The Alliance shall provide the following information to an enrollee with a terminal illness within five (5) business days of a denial coverage for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider:~~

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1. A statement setting forth the specific medical and scientific reasons for denying coverage.
2. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
3. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.

B. Upon receiving a complaint form requesting a conference pursuant to paragraph (3) of subdivision (a) of CA Health and Safety Code §1368.1 (b), the plan shall provide the enrollee, within 30 calendar days, an opportunity to attend a conference:
1. To review the information provided to the enrollee pursuant to paragraphs (1) and (2) of CA Health and Safety Code §1368.1 subdivision (a);
2. Conducted by a plan representative having authority to determine the disposition of the complaint;
3. The plan shall allow attendance, in person, at the conference, by an enrollee, a designee of the enrollee, or both, or, if the enrollee is a minor or incompetent, the parent, guardian, or conservator of the enrollee, as appropriate;

However, the conference required by CA Health and Safety Code §1368.1 subdivision (a) shall be held within five business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date.

C. Guidelines to Identify a Terminally Ill Diagnosis or Condition
1. The Alliance uses written utilization review criteria based on sound medical evidence, consistently applied, regularly updated, and annually reviewed and approved by the Quality Improvement Health Equity Committee (QIHEC)
1. MCG (formerly Milliman Care Guidelines) Guidelines are licensed and approved for use as a primary reference in the medical necessity decision making process. Other applicable publicly available guidelines from recognized medical authorities are referenced, when indicated.
1. National Coverage Determinations and Local Coverage Determinations are also utilized for D-SNP members
1. Of the four levels of hospice care as described in Title 22, CCR, Section 51349 only general inpatient care is subject to prior authorization. Documents to be submitted for authorization include:
    1) Levels of Care
        (a) Routine home care
        (a) Continuous home care requiring a minimum of eight hours of care per 24-hour period
        (a) Respite care provided on an intermittent non-routine, and occasional cases for up to five consecutive days at a time
        (a) General Inpatient care for pain and symptom control

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~~i. Documents to be submitted for authorization include:~~
~~1. Certification of physician orders for general inpatient care.~~
~~2. Justification for this level of care.~~

~~2. The Alliance's policies shall conform to the statutory definition of terminal illness: "Terminally ill means the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course."~~

~~D. Communication of Denial Determination~~

~~Requesting provider and Member written notifications for denied requests related to a terminal illness will include a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity.~~

~~1. The denial Notice of Action (NOA) letter includes statements about the specific medical and scientific reasons for denying coverage.~~

~~1. The denial NOA letter will include, if appropriate, a description of alternative treatment, service, or supply covered by the Alliance.~~

DEFINITIONS / ACRONYMS

~~A. Terminally ill is defined in:~~

~~0. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.~~

~~0. CA Health and Safety Code § 1368.1(a) as an incurable or irreversible condition that has a high probability of causing death within one year or less.~~

~~D. Hospice Care is defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.~~

~~E.~~ Crisis Period: ~~Palliative care means that hospice care given as it relates to the individual's terminal illness will be palliative rather than curative in nature. Interventions focus primarily on reduction and abatement of pain and other disease-related symptoms rather than interventions aimed at investigation and/or cure or prolongation of life. See Health and Safety Code §1339.31(b)~~

A. ~~T~~~~Crisis is t~~he period in which the member requires continuous care for as much as 24-hours to achieve palliation or management of acute medical symptoms. Care provided requires a minimum of eight hours of primarily nursing care within a 24-hour period commencing at midnight and terminating on the following midnight. The eight hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is needed.

B. Hospice Care is defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.

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C. Hospice Election Period- A defined period of time during which a patient has formally chosen (elected) to receive hospice care instead of curative treatment for a terminal illness, and during which hospice benefits are active.

D. Interdisciplinary Team (IDT) A group of healthcare professionals from different disciplines who work collaboratively to develop, implement, and manage a patient-centered plan of care for individuals receiving hospice services.

E. Interdisciplinary Care Team (ICT)- A collaborative group of healthcare and service professionals, along with the member and/or their caregiver, who work together to assess needs, develop, implement, and coordinate a comprehensive, person-center care plan.

F. Palliative Care- Palliative care means that hospice care given as it relates to the individual's terminal illness will be palliative rather than curative in nature. Interventions focus primarilyon reduction and abatement of pain and other disease-related symptoms rather than interventions aimed at investigation and/or cure or prolongation of life. See Health and Safety Code §1339.31(b)

G. Terminal Illness is defined in:

a. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.

b. CA Health and Safety Code § 1368.1(a) as an incurable or irreversible condition that has a high probability of causing death within one year or less.

~~F.~~

~~**Delegation Oversight**~~

~~The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.~~

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-400 Delegation Oversight
CLM- 015

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENT

None

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REVISION APPROVAL HISTORY

1/1/2008, 10/28/2009, 8/30/2012, 10/30/2013, 3/04/2015, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 10/19/2023, 12/18/2024, 12/17/2025, 5/27/26

REFERENCES

A. CA Health and Safety Code §1368.1(a) (b)
B. DHCS Contract, Exhibit A, Attachment 10, Provision 8.C.
~~B.~~C. DHCS APL 26XXX (Draft) Hospice Services and Medi-Cal Managed Care
~~C.~~D. CCS NL: 04-0207 Palliative Options for CCS Eligible Children
~~D.~~E. CCS NL: 06-1011 Authorization-Concurrent Treatment for CCS Clients Who Elect Hospice
~~E.~~F. MMCD All Plan Letter 13-014 Hospice Services and MCMC
~~F.~~G. MMCD Policy Letter 11-004 ACA –Concurrent Care for Children
~~G.~~H. Title 22, CCR, Sections 51180 and 51349
I. Social Security Act §1905(o)(1)
~~H.~~

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MONITORING

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

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POLICY AND PROCEDURE

Policy Number	UM-014
Policy Name	Identifying and Reporting Potential Child, Adult or Elder Abuse
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/21/2006
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

PCPs are responsible for the overall health care of assigned Members including the identification and reporting of suspected child, adult, or elder abuse cases.

PROCEDURE

A. Information sources available to network practitioners to assist with the identification of possible Member abuse cases include the following:

1. Requests by an Emergency Room for authorization to treat an illness or injury of suspicious or questionable nature;
2. Request by an Urgent Care Center for authorization to treat an illness or injury of suspicious or questionable nature;
3. Hospitalization of a Member for suspicious trauma, illness, or injury;
4. Office visits with Pediatricians, PCPs, Behavioral Health providers and other health care practitioners that reveal unusual physical or emotional findings;
~~4.~~
5. During the administration of the ACES screen, the PCP, Pediatrician or Behavioral

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Health provider may identify instances of potential child abuse/neglect.

6. Grievance and Appeal Process: D-SNPs must maintain accessible grievance procedures per 42 CFR §§ 422.561–422.564 and § 422.630, enabling members to report abuse of neglect directly to the plan.

~~a.~~

~~0. Grievance and Appeal Process: D-SNPs must maintain accessible grievance procedures per 42 CFR §§ 422.561–422.564 and § 422.630, enabling members to report abuse of neglect directly to the plan.~~

7. Cases identified during the Utilization Management, Case Management, Long-Term Care, CCS, or Behavioral Health processes;

~~5.~~

8. D-SNP members receiving LTSS Services through the MCP are asked questions during their Health Risk Assessment (HRA) related to Abuse and Neglect as a potential Social Determinant of Health Risk Factor.

9. Requests for assistance received by Member Services;

B. Healthcare providers must be alert for signs of physical or mental abuse including, but not limited to, the following signs and symptoms:

1. Abuse Perpetrated by Others (WIC 15610.07 & 15610.63)
   a) Physical (e.g. assault/ battery, constraint or deprivation, chemical restraint, over/ under medication)
   b) Sexual
   c) Financial
   d) Neglect (including Deprivation of Goods and Services by a Care Custodian)
   e) Abandonment
   f) Isolation
   g) Abduction
   h) Psychological/ Mental

2. Self-Neglect (WIC 15610.57 (b)(5)):
   a) Neglect of physical care (e.g. personal hygiene, food, clothing, malnutrition/ dehydration)
   b) Neglect of Residence (unsafe environment)
   c) Financial Self-Neglect (e.g. inability to manage one's own personal finances

C. Alameda Alliance for Health and Alameda Alliance Wellness (The Alliance) network practitioners are responsible for filing reports of suspected child and elder abuse to the appropriate agencies as follows:

Child Abuse:
Alameda County
Social Services Agency, Child, and Family Services

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Commented [MF2R1]: @Glasby, Kimberly

Commented [GK3R1]: @Findlater, Michelle I have not seen the HRA. @Hunter, Lily Is this is the HRA?

Commented [HL4R1]: I edited the sentence to read, "DSNP members receiving LTSS Services through the MCP are asked questions during their Health Risk Assessment (HRA) related to abuse and neglect as a potential social determinant of health risk factor."

There are a series of questions in the HRA that refer to various types of abuse (physical/emotional, financial, etc.).

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Child Protective Services
(510) 259-1800

Adult and Elder Abuse:
Alameda County Social Services Agency
Department of Adult and Aging Services
Adult Protective Services
(510) 577-3500

D. Long-Term Care members residing in facilities such as Skilled Nursing Facilities, Sub-Acute Facilities, Long-Term Acute Care (LTAC) Facilities and Intermediate Care Facilities for the Developmentally Delayed (ICF/DD) are responsible to notify the Office of the Ombudsman with any reports of Abuse.

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1. Long-Term Care Ombudsman representatives assist residents in Long-Term Care facilities with issues related to day-to-day care, health, safety, and personal preferences. Problems can include, but are not limited to:
    a. Violation of residents' rights or dignity
    b. Physical, verbal, mental, or financial abuse
    c. Poor quality of care
    d. Dietary concerns
    e. Medical care, therapy, and rehabilitation issues
    f. Medicare and Medi-Cal benefit issues
    g. Improper transfer or discharge of a resident
    h. Inappropriate use of chemical or physical restraints

2. The Alliance Staff and Network Practitioners are responsible for filing reports of suspected child and elder abuse to the appropriate agencies as follows:

    Department of Adult and Aging Services
    Long-Term Care Ombudsman
    (510) 638-6878

3. The Alliance is also responsible to report any Critical Incidents as defined by DHCS on a quarterly basis for those members residing in a Long-Term Care Facility.

4. The Alliance is responsible to ensure that the contracted network of providers are compliant with 42 C.F.R. §§483.13(c)(2)(3) and (4).
    a. Providers must report any alleged violations including:
        - Mistreatment
        - Neglect
        - Abuse
        - Injuries from an Unknown Source
        - Misappropriation of resident Property

E. Reporting Timeframes:

1. The facility must follow the timeframes established in the regulations; that is, the facility must ensure that all alleged violations are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures (including to the state survey and certification agency in accordance with 42 C.F.R. §483.13(c)(2), and the results of all investigations must be reported to the administrator or his/her designated representative and to other officials in accordance with state law (including to the state survey and certification agency) within 5 working days of the incident in accordance with 42 C.F.R. §483.13(c)(4).

2. CMS believes "immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter state timeframe requirement. Conformance with this definition requires that each state has a means to collect reports, even on off-duty hours (e.g., answering machine, voice mail, fax).

F. PCPs, Pediatricians or Behavioral Health providers may request assistance from the Case Management department to facilitate coordination of care for members for whom mandatory reporting is required.

G. Delegated Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-400~~019~~ for monitoring of delegation oversight.

DEFINITIONS / ACRONYMS

~~1.~~ **Critical Incidents:** Reportable to DHCS on a quarterly basis, Critical Incidents are defined as occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, and any instances of suspected or alleged abuse, neglect, exploitation and/or mistreatment.

~~2.~~ **Mistreatment** - (A definition is not provided at this time.)

~~3.~~ **Neglect** - Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness (42 C.F.R. §488.301).

~~4.~~ **Abuse** - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R. §488.301).

~~5.~~ **Injuries of unknown source** - An injury should be classified as an "injury of unknown source" when both of the following conditions are met:

- The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and,
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

~~6.~~ **Misappropriation of resident property** - The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent (42 C.F.R. §488.301).

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-400 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

1/1/2008, 10/28/2009, 8/30/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 7/17/2024, 9/17/2025, 5/27/2026

REFERENCES

42 C.F.R. §§483.13(c)(2)(3) and (4).
42 C.F.R. §488.301
Adult Protective Services Program Form SOC 341A
CA Welfare and Institutions Codes WIC 15610.07 & 15610.63 & 15610.57 (b)(5)):
DHCS APL 22-018
DHCS CalAIM D-SNP Policy Guide 2025
DHCS Contract Exhibit A, Attachment 11
(WIC 15610.07, WIC 15610.57 (b)(5)) & 15610.63)

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MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity/ Utilization Management (QIHE/UM) Committee and Administrative Oversight Committee annually.

~~1.~~

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POLICY AND PROCEDURE

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Policy Number	UM-023
Policy Name	Communicable Disease Reporting and Services~~-Services~~
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	10/12/2006
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

A. The Alliance requires health care practitioners follow all applicable Federal, State, and local statutes, regulations, or ordinances for the reporting of communicable diseases, and to implement directives from public health authorities. Practitioners or Providers must ensure that any Member with a reportable communicable disease is reported to public health authorities according to the appropriate statutes, regulations, or ordinances

B. Failure to report communicable diseases as required by statute, regulation or ordinance can result in negative action taken by the Medical Board of California or the Alliance as circumstances warrant.

C. AAH provides all medically necessary covered services to members with TB while on Direct Observed Therapy (DOT)

PROCEDURE

A. The date of public health authority contact, name of contact, and signature of contacting person is documented in the medical record. Reporting is conducted in accordance with the following:

1. State law requires that health care practitioners report specified communicable diseases. Physicians, nurses, dentists, coroners, laboratory directors, school officials and other people knowing of a case or suspected case of any of the diseases or conditions listed in Section C are required to report them to the local

Department of Health. (California Administrative Code, Title 17, Sections 2500, 2502, 2503, 2504, 2505 and 2508).

2. The report to the public health authorities shall be documented in the Member's Medical Record and include the report date, the contact at the public health authority, and the reporter's signature.

B. Alameda Alliance's Providers and practitioners must use the following guidelines for Public Health reporting:

1. Extremely Urgent Conditions (*) - should be reported immediately by telephone, 24 hours a day, to the after-hour emergency number listed below.

2. Other Urgent Conditions (+) - should be reported by telephoning, mailing, or electronically submitting a report within one (1) working day of identification of case or suspected case.

3. All Other Non-Urgent Conditions may be reported by phone or by mail on confidential morbidity report cards within seven (7) days of identification.

~~3.~~

C. PCPs are required to refer all confirmed (class III) or highly suspected (class V) active TB cases, pulmonary or extra pulmonary, to the Local Health Department (LHD) in Alameda County. The cases must be reported on the same day of suspicion or diagnosis, by phone.

~~C.~~

D. PCPs are required to cooperate with any request from the LHD for medical records, diagnostic test results, and any other pertinent clinical, case contact, or administrative information

~~D.~~

E. LHDs are responsible for receiving disease reports and coordinating follow-up action between local, regional, and state officials.

~~E.~~

F. Investigations of reportable communicable diseases by Local or State Health Departments (source case/case contact follow-up investigations) are exempt from HIPAA regulation and all information requests shall be provided.

1. No patient consent for release of information is needed.

Alameda County Public Health Department
Division of Communicable Disease Control & Prevention 1100 San Leandro Boulevard, San Leandro, CA 94577Phone: (510) 267-3250 (M-F, 8-5) Phone: (925) 422-7595 (After hours, Weekends) Website: http://www.acphd.org/, A-Z Listing: Communicable Disease Control & Prevention
Alameda County Public Health Department

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Tuberculosis Control Program
Phone: (510) 667-3096
www.acphd.org/**tb**/**tb-control**.aspx
A-Z Listing: Tuberculosis Control Program – (Clinicians)

City of Berkeley Public Health Department

Communicable Disease Reporting
Phone: (510) 981-5292
Provider Resources | City of Berkeley

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G. Case Management

1. Alliance's Network of PCPs are required to inform their Delegated Medical Group or the Alliance's Medical Services staff of any Member referred to the LHD Tuberculosis Program for active or highly suspected active TB.
2. Alliance staff, with LHD Tuberculosis Program collaboration, must identify and address barriers to patient compliance with self-administered treatment. To improve adherence, The Alliance's formulary offers fixed-dose combination drug preparations.
3. Alliance Medical Services staff coordinates care for Members who have active TB and other co-morbid medical conditions such as those listed as reportable by California Department of Public Health.
   Reportable Disease and Conditions

H. Direct Observed Therapy

1. Direct Observed Therapy (DOT) for the treatment of Tuberculosis is provided by the LHD and is not covered by the Alliance.
2. For Members receiving treatment for TB disease, the PCPs must share clinical information with the LHD's TB Control Program as needed and requested.
3. The PCP must promptly notify the LHD TB Control Program of any significant changes in the Member's condition, failure to keep appointments, decision to discontinue medications, change in address, or response to medical treatment including adverse drug reactions and dosage changes.
4. The Alliance provides all medically necessary medication for Members with TB, via the contracted pharmacies.
5. The Alliance provides all medically necessary covered services to members with TB while they are on DOT following the UM Hierarchy outlined in the UM Program Description and all DHCS and CMS regulations.

I. Hospital Transfers and Discharge

1. Hospital infection control staff, including the attending physician, are required to submit a hospital discharge plan to the LHD for approval prior to discharge or transfer of an inpatient case of active TB, per California Health and Safety Code, Section 121361. No patient will be discharged or transferred, unless the transfer is

necessary for medical/surgical emergencies, without prior written approval of the LHD.

2. Hospital personnel must use the required form provided by the LHD. This form is available online.

J. Reporting

1. A list of reportable diseases, reporting timeframes and reporting methods are available from the California Department of Public Health Website under the Division of Communicable Disease Control, Reportable Diseases and Conditions Website.
2. Alliance Providers are required to comply with all State laws and regulations pertaining to reporting of confirmed and suspected TB cases to the LHD. Alliance Providers must report known or suspected cases of TB to the LHD TB control programs within one day of identification per Title 17, CCR, Section 2500.
3. The local health officer may, per State law, require Alliance practitioners at any time to report any clinical information deemed necessary by the local health officer to protect the Member's health or the health of the public.

K. Contact Investigation and Treatment

1. The Alliance requires that all PCPs and Delegated Medical Groups cooperate with the LHD in conducting contact and outbreak investigations potentially involving Members. The Alliance is available to facilitate and if necessary, direct the coordination efforts between the LHD and Alliance PCPs and Delegated Medical Groups.
2. The Alliance requires PCPs and Delegated Medical Groups to provide appropriate examination and treatment to Members identified by the LHD as contacts in a timely manner (usually within seven days). Examination results must be reported back to the LHD Tuberculosis Program staff in a timely manner. The Alliance coordinates with PCP and the Delegated Medical Groups to promptly notify the LHD Tuberculosis Program staff when contacts of Members are referred to the LHD Tuberculosis Program staff for care.

L. Laboratory Services

1. Sputum smears and cultures must be obtained from Members with pulmonary TB at least monthly, or as clinically indicated, until culture results are documented negative for two consecutive months. More frequent monitoring may be required for multidrug-resistant TB or cases with poor treatment response, and alternative diagnostics may be used when sputum collection is not feasible.

M. Delegation Oversight

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

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Refer to CMP- 019 for monitoring of delegation oversight.

DEFINITIONS

Centers for Disease Control and Prevention (CDC) focuses national attention on developing and applying disease control and prevention.

Local Health Department (LHD) a governmental agency that provides public health services at the community level, focusing on promotion health and preventing disease among residents.

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AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-400 Delegation Oversite and Monitoring

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

1/1/2008, 1/16/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 4/16/2019, 5/21/2020,
5/20/2021, 6/28/2022, 6/20/2023, 9/19/2023, 12/18/2024, 09/17/2025, 7/23/2026

REFERENCES

1. California Health and Safety Code, Sections 1900-2000
2. DHCS Contract Exhibit A, Attachment 10.5.C and E; 10. 6. C and 8. F; 11.14 and16; and 12. 2
3. Title 17, CCR, Sections 2500, 2502, 2503, 2504, 2505 and 2508
4. UM Program Description

MONITORING

The Compliance and Utilization Department will review this policy annually and as needed for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC) annually.

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POLICY AND PROCEDURE

Policy Number	UM-036
Policy Name	Continuity of Care for Terminated and Non- Participating Providers
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	1/1/2008
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

Overview

The Alliance provides for the completion and continuity of covered services by a terminated or out-of-network/non-participating provider (NPP) of any type at the member's request in accordance with Health and Safety Code Section 1373.96, including medical and mental health service providers.

Policy Statement

A. Current and Newly Enrolled Group Care, D-SNP and Medi-Cal Members
   1. Upon their request, current Alliance Members or newly enrolled Members with specified conditions may continue to obtain an Active Course of Treatment and health care services from a terminated or non-contracted provider for a specific condition and time frame as noted below:
      1. **An acute condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
      2. **Serious chronic condition** is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of active treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with the Member and the terminated provider or non-contracting provider, consistent with good

professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.

3. **Pregnancy** is the three trimesters of pregnancy and the immediate postpartum period. Services shall be covered for the duration of the pregnancy and the immediate postpartum period of 12 months. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition must not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
4. **Terminal illness** is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services is provided for the duration of the terminal illness which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.
5. **Newborn childcare** is the care of a newborn child between birth and age thirty-six (36) months. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.
6. **Performance of a surgery or other procedure** is a medical procedure that is authorized by the Alliance, if a current Member, or by a previous plan, if a new Member, as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the effective date of coverage for a newly enrolled Member, or within 180 days of the termination of the provider for a current Member.
7. **Pediatric Palliative Care** is a patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering for children. Members currently enrolled in the Alliance or transitioning from Medi-Cal FFS, the Alliance will allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network provider. The Alliance will not provide continuity of care for services that were excluded due to the PPC Waiver Program and that are not also covered by Medi-Cal under EPSDT per DHCS requirements.

2. The terminated or NPP must agree to terms and conditions and rates consistent with those used by the Alliance or provider group in the same or similar geographic area.
    a. If provider refuses rates or terms, The Alliance will make every effort to transition member to an appropriately qualified in-network provider.
    b. If a qualified in-network provider is not available, The Alliance will continue to negotiate rates or locate another qualified provider to care for member.
3. This policy is not applicable for current Members if the provider was terminated for medical disciplinary cause, fraud, abuse of the Medi-Cal program or any patient, convicted of a felony or other criminal activity, suspended from the federal Medicare or Medicaid programs for any reason, lost or surrendered a license certificate or approval to provide health care or newly covered enrollees with individual coverage.
4. Continuity of Care shall not be authorized or continued for any provider who is excluded,

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suspended, precluded, debarred, or otherwise ineligible to participate in Medi-Cal, Medicare, or any other federal health care program. This includes providers identified on federal or state exclusion databases, including but not limited to the OIG LEIE, CMS Preclusion List, SAM exclusion database, and DHCS suspension or exclusion lists.

~~3.~~5. The Alliance will not enter into a Letter of Agreement or continuity of care arrangement with a provider who is excluded, suspended, precluded, or otherwise prohibited from participation in state or federal health care programs.

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B. On January 1, 2024, Alameda County transitioned to a Single Plan Model county, and Medi-Cal recipients transitioned from a previous Medi-Cal Managed Care Plan (MCP) to Alameda Alliance for Health (AAH) as their MCP. During the transition, AAH will adhere to the requirements of APL 23-018 Managed Care Health Plan Transition Policy Guide (Policy Guide), which establishes the 2024 Managed Care Plan Transition Policy Guide as the DHCS authority, along with the applicable Contract, and any incorporated APLs or guidance documents incorporated into the Policy Guide by reference, regarding the 2024 MCP transition.

1. The AAH policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

2. Particular attention and resources will be focused on members in Special Populations:
   a. Adults and children with authorizations to receive Enhanced Care Management (ECM) services
   b. Adults and children with authorizations to receive Community Supports (CS).
   c. Adults and children receiving Complex Care Management (CCM)
   d. Enrolled in 1915(c) waiver programs
   e. Receiving in-home supportive services (IHSS)
   f. Children and youth enrolled in California Children's Services (CCS)
   g. Children and youth receiving foster care, and former foster youth through age 26
   h. In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
   i. Taking immunosuppressive medications, immunomodulators, and biologics
   j. Receiving treatment for end-stage renal disease (ESRD)
   k. Living with an intellectual or developmental disability (I/DD) diagnosis
   l. Living with a dementia diagnosis
   m. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
   n. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
   o. Receiving specialty mental health services (adults, youth, and children)
   p. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
   q. Receiving hospice care
   r. Receiving home health

s. Residing in Skilled Nursing Facilities (SNF)
t. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
u. Receiving hospital inpatient care
v. Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
w. Newly prescribed DME (within 30 days of January 1, 2024)
x. Members receiving Community-Based Adult Services (CBAS)

3. See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

C. The Alliance will maintain standards of communication and processes for the appropriate sharing of information (e.g., adequate, timely feedback and consultation) and coordination of care between and among medical and mental health providers, general and specialty practitioners, and institutions, referring and consulting providers.

D. For Group Care Mental Health Services (employer-sponsored group health), The Alliance:
1. Maintains a process for block transfers of enrollees from a terminated provider group to a new provider group or hospital.

2. Maintains a process to facilitate the CoC for a new enrollee who has been receiving services from a NPP mental health provider for an acute, serious, or chronic mental health condition when an employer changed health plans. This includes a reasonable transition period to continue the course of treatment with the NPP prior to transferring to a participating provider and includes the provision of mental health services on a timely, appropriate, medically necessary basis from the NPP. The process provides that the length of time of the transition period take into account on a cases-by-case basis, the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. The process ensures that reasonable considerations are given to the potential clinical effect of a change of provider on the Member's treatment of the condition. The process describes the process to review a Member's request to continue the course of treatment with the NPP mental health provider.

3. NPP mental health are not required to be contracted with The Alliance or its delegate but will require a written contract as a condition of the right to treatment an Alliance Member defining the same contractual terms and conditions that are imposed upon the participating providers, including location within the service area, reimbursement methodologies and rates of payment. This will include a quality review assessment of the NPP mental health provider.
    a. When The Alliance determines that a member's health care treatment should temporarily continue with an existing provider or NPP mental health provider, the Alliance shall not be liable for actions resulting solely from the negligence, malpractice, or the tortious or wrongful acts arising out of the provisions of service by the existing provider or a NPP mental health provider.

4. Facilitates the completion of covered services pursuant to H&S Section 1373.96.

5. Provides Evidence of Coverage for Member communication describing the policy and informing Members of their rights to the completion of covered services.

6. Maintains processes to ensure that reasonable consideration is given to the potential clinical effects on a Member's treatment caused by a change in provider.

E. On January 1, 2026 the Alliance will allow for Continuity of Care for Medicare Primary and Specialty Providers Upon a Member, authorized representative, or provider's request, D-SNPs must offer continuity of care with out-of-network Medicare providers to all Members if all of the following circumstances exist:

1. A Member has an existing relationship with a primary or specialty care provider. An existing relationship means the Member has seen an out-of-network primary care provider (PCP) or a specialty care provider at least once during the 12 months prior to the date of their initial enrollment in the D-SNP for a non-emergency visit;

2. The provider is willing to accept, at a minimum, payment from the D-SNP based on the current Medicare fee schedule, as applicable; and

3. The provider does not have any documented quality of care concerns that would cause the D-SNP to exclude the provider from its network.

4. If the Member leaves the D-SNP and later rejoins the D-SNP, then the D-SNP must offer the Member a 12-month continuity of care period based on the date of re-enrollment, regardless of whether the Member received continuity of care in the past. If a Member changes D-SNPs, the continuity of care period may start over one time. If the Member changes D-SNPs a second time (or more), the continuity of care period does not start over, meaning the D-SNP is not required to offer the Member a new 12-month period.

F. In the event a provider is terminated, all assigned Members are notified in writing (Attachment A) of the termination and their right to continue care 60 days prior to the termination effective date and are informed of the procedures for selecting another provider.

G. The Alliance maintains mechanisms to facilitate transition of care (including enrollee notification when:

1. An individual in a course of treatment enrollees in the Plan and

2. When a medical group or provider is terminated from the network.

H. The Alliance reserves the right to make final decisions regarding continuity of care.

1. An Alliance Medical Director makes such decisions with consideration given to the potential effects on the Member's clinical condition and whether they are receiving an active course of treatment for acute or chronic conditions.

I. Communication to Members:

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 Evidence of Coverage and Disclosure Forms, and upon request, the Alliance sends a copy of the policy to the Member.

J. Any newly enrolled Member request COC or may obtain a copy of this policy upon written request to Alliance or by calling Member Services

K. The Alliance is not required to cover services that are not otherwise covered by the Plan.

L. The Alliance notifies members of alternative resources in situations when members are receiving approved and medically necessary services but whose benefit coverage will? end or has ended.

M. The Alliance will manage the process of care transitions, identify problems that could cause transitions, facilitate safe transitions and, where possible, prevent or minimize unplanned transitions.

N. The Alliance Medical Services, Case and Disease Management Departments and their supporting units as well as the Member Services Department will collaborate in the management of care transition processes. This process includes review to determine whether the member's current treatment/care is transferable to another provider without compromising quality of care.

O. The Alliance utilizes evidenced based criteria, the application of medical necessity and reasonable consideration to the potential clinical effects on the Members' treatment caused by a change in Provider in consideration of a continuation of care.

P. The Alliance may delegate this responsibility to a provider group and ensures that the requirements are met.

Q. The Alliance reserves the right to make all final decisions regarding continuity of care for Alliance Members.

PROCEDURE

A. All newly enrolled Members receive the Alliance's notice of the continuity of care policy in the Evidence of Coverage and Disclosure Form that is sent at time of enrollment.

1. Former Covered California members transitioning into Medi-Cal, Seniors and Persons with Disabilities with active Treatment Authorization Requests, and individuals identified on the Exemption Transition Data Report will receive additional outreach regarding continuity of care from the Member Services Department.

B. CoC requests are managed using the same mechanisms and processes for both medical and mental health services.

~~C.~~ Requests from newly enrolled Members to continue their care with a NPP of any type will typically originate with the Outpatient Utilization Management Department.

C.

1. Any such request is documented by Alliance Utilization Management Department with subsequent referral to an Alliance Medical Director, if necessary.

2. The Alliance UM Department Standards to begin review of request for CoC within:
   ~~a.~~ Refer to UM-051 Attachment A UM Timeliness Policy~~Routine request within five (5) business days.~~
   ~~b.~~a. ~~Urgent matters are reviewed and responded to within 72 hours.~~

3. Each continuity of care request must be completed within the following timeline:
   a. Thirty calendar days from the date The Alliance received the request;
   b. Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
   c. Three calendar days if there is risk of harm to the member.
   d. Note: timeframes may be extended due NPP contracting phase; contracting should be completed within the standard timeframe but not to exceed 30 calendar days from the date of the receipt of the request.
   e. For D-SNP, Retrospective Requests are reviewed and responded to within 30 calendar days from the first date of service for which the provider is requesting or has previously requested, continuity of care, retroactive reimbursement; and
   f. Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested or denial from another entity when the claim was incorrectly submitted.

4. Alliance Medical Services will evaluate the request based on the regulatory requirements outlined in Health and Safety Code Section 1373.96.

5. Alliance Medical Services will notify Alliance Contracts Management via a Health Suite Service Request of all approved authorizations.

6. Alliance Medical Services will notify Alliance Contracts Management via a Health Suite Service Request of all approved authorizations.

7. UM Coordinators are responsible for daily monitoring HealthSuite Service Request email distribution inbox.

8. UM Coordinators will review each request for:
   a. Eligibility
   b. Confirmation of Provider network status
   c. Obtaining medical records, if necessary
   d. Assignment to UM Nurse for review

D. UM Nurse Specialist/ Reviewer is responsible for reviewing each Member or NPP request for CoC.
   1. Requests are reviewed based on the member conditions.

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E. UM Nurse Specialist or designee will contact the Provider to confirm the request and obtain any additional information as needed.

F. The UM Nurse Specialist/ Reviewer is responsible for ensuring communication among the providers between all levels of care (e.g. acute inpatient care, sub-acute admissions, outpatient care/treatment) will contact the appropriate The Alliance delegate's UM Staff or to facilitate the timely exchange for co-management. UM Nurse Specialist/ Reviewer or designee will contact the requested NPP to confirm agreement to of existing active treatment plan or criteria met and NPP agreement to continue services to Member.

1. Once information is obtained, the request is forwarded to The Alliance Medical Director to confirm CoC exists and meets criteria.
    a. If criteria met, the UM Coordinator will notify the Alliance Contracts Management team via Health Suite SR process with all applicable information to begin rate negotiations.
    b. The UM coordinator will generate an approval level for Continuity of Care as outlined by regulation to all applicable parties.
    c. If criteria is not met, the Alliance Medical Director will document the reason for the denial of the determination in the UM Clinical Information System.
        - The UM Coordinator will create communication to the member and provider(s) as scribed by the Medical Director.UM Coordinator will contact the assigned PCP and Provider Group to ensure communication of the denial and coordination of necessary medical treatment.

G. For Mental Health Services

1. The Behavioral Health (BH) department staff are responsible for ensuring the review of request for CoC with a NPP mental health provider.

2. For services that require co-management, the BH staff are responsible for ensuring communication among the providers between all levels of care (e.g., inpatient care, partial hospitalization, outpatient care, day, and residential treatment) and will facilitate the timely exchange of information for co-management.

3. When needed, the BH staff will ensure communication between and among BH and medical providers to ensure appropriate evaluation, screening, diagnosis, and treatment of serious mental health illness, serious emotional disturbances, and autism conditions.

H. Rates of Payment and Agreement of Terms

1. Through a Letter of Agreement, Alliance Contracts Management Department will offer the non- contracted providers who may continue services:
    a. The rates and methods of payment similar to those used by the Alliance or the provider group for currently contracted providers providing similar services or the Medi-Cal fee for service rate, whichever is higher.
    b. The rates offered will be for providers who are not capitated and who are practicing in the same similar geographic areas as the non-contracting provider.
    c. The NPP will be subject to the same contractual terms and conditions as contracting

providers.

2. If the NPP agrees to the rate, terms and conditions, Contract Management notifies Medical Services and Medical Services sends to the member and the provider a notice authorizing the continued services.

3. If the NPP does not agree to the rates, or terms and conditions or fails to respond to the Alliance within 30 calendar days of the request for continuity of care, the following will occur:
    a. Contract Management will notify Alliance Utilization Management to implement the administrative process to void the authorization.
    b. Alliance Utilization Management will send the member and the provider a notice that continuity of care services have been denied because the Alliance and the non-contracted provider were unable to reach agreement.
    c. Utilization Management will coordinate with Case Management to identify an alternative provider for the member to continue receiving care with a contracted provider.

I. UM Nurse Specialist or designee will contact the requested Provider to confirm agreement to of existing active treatment plan or criteria met and NPP agreement to continue services to Member.

1. Once information obtained,
    a. The UM Coordinator will notify the Member and NPP in writing as well as the assigned PCP and assigned Provider Group to ensure necessary documentation as well as verification of primary care continuing as the responsibility of the Provider Group.

J. In situations when members are receiving approved and medically necessary services but whose benefit coverage ends, the Alliance notifies members of the existence of alternative resources. (Attachment B).

K. Managing Transitions/Members in hospital or sub-acute setting at the time of the termination

1. Identification of planned transitions from members' usual setting of care to the hospital and transitions from the hospital to the next setting.
    a. Planned/Unplanned Transitions. All elective inpatient admissions require prior authorization by the Alliance or a delegated Provider Group.
        1) For terminating providers/ Contracted Facilities, The Alliance/Provider Groups will obtain a list of all maintain paper and electronic files on all authorization requests to identify Members who may be impacted by the termination.
    b. For newly enrolled Members who are hospitalized at the time of the assignment to The Alliance and who meet the criteria noted in Section 2.1, the UM Nurse Specialist will review each case with the UM Medical Director and follow the stated procedures in this section.

L. Honoring Existing and Active Prior Treatment Authorizations (PAs) and Treatment Authorization Requests (TARs)

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1. For terminated providers, the UM Department will collaborate with Provider Relations to ensure any associated Provider Groups are notified of these specific members with an existing and active PA or TAR that the Alliance or the delegate will honor the PA or TAR for ninety (90) days or until an appropriate assessment is completed by a contracted provider.

M. Block Transfers – Please refer to the Alliance's Block Transfer P&P for the Alliance's process for handling the termination of a Provider contract that could involve the block (entire) transfer of Members.

N. Delegated Providers

1. The Alliance will ensure compliance with the regulatory requirements for continuity of care by delegated groups and oversee the compliance through the delegation oversight process; i.e., quarterly reporting, annual on-site review, investigation of complaints, and review of denials.

2. Any written, printed, or electronic notification to the Member regarding a contract termination or block transfer (transfer of all of a provider's Members) must include the following language: "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact The Alliance's Member Service Department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov".

O. Continuity of Care Reporting Requirements:

1. The Analytics, IT and Medical Services Departments will work together in order to ensure the Alliance submits all required quarterly continuity of care reports.

2. On a monthly basis, the UM Manager or designee will review CoC data and reporting requirements to ensure data is available for internal and regulatory reporting.

3. On a quarterly basis, the UM Manager and UM Director will review the CoC data and provide a summary report with identification of opportunities to improve the UM experience to the UM Committee.

4. On a monthly basis, the IT department and/ or Analytics department will provide data to the Compliance Department for regulatory reporting.

DEFINITIONS

Active Treatment - An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol.

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Excluded Provider – An individual or entity that has been excluded, suspended, debarred, or otherwise determined ineligible to participate in Medicare, Medicaid/Medi-Cal, or other federally funded health care programs by a federal or state authority, including but not limited to the U.S. Department of Health and Human Services Office of Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS), or the California Department of Health Care Services (DHCS). An excluded provider may not receive payment from federal health care programs and may not be employed, contracted with, or utilized by the health plan in a manner prohibited by applicable law and regulation.

Individual Provider – A health care professional licensed, certified, or otherwise authorized under California law to provide covered health care services within the scope of their practice.~~A person who is licentiate, as defined in Section 805 of Business and Professional Code or a person licensed under Chapter 2 of Division 2 of the Business and Professions Code.~~

Nonparticipating Mental Health Provider – A licensed behavioral health professional who is not contracted with the Alliance or delegated provider network to provide covered behavioral health services to members.
~~A psychiatrist, licensed psychologist, licensed marriage and family therapist, licensed social worker, or licensed professional clinical counselor who does not contract with the specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.~~
Non-participating Provider (NPP) - A provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.

Non-Contracted Provider – Any provider that is not contracted with the Alliance.

Planned Transitions~~-~~ -An anticipated transfer of a member from one care setting, provider, health plan, or level of care to another that occurs as part of an organized treatment plan, including but not limited to elective surgery, discharge planning, transfers to post-acute care, or admission to a long-term care facility.
~~include elective surgery or a decision to enter a long-term care facility.~~
Post-Partum Period – The period following childbirth during which postpartum-related services are medically necessary. For continuity-of-care purposes, the postpartum period shall be determined based on applicable state and federal requirements and the member's clinical needs.
~~Commonly defined as the six weeks after childbirth.~~
Precluded Provider – An individual or entity identified on the CMS Preclusion List and prohibited from receiving payment for services, items, or drugs furnished to Medicare Advantage or Medicare Part D enrollees. Placement on the CMS Preclusion List generally results from conduct such as revocation of Medicare enrollment, exclusion from federal health care programs, or other actions determined by CMS to present program integrity concerns.

Provider – An individual professional, medical group, facility, agency, institution, or other entity licensed, certified, registered, or otherwise authorized under applicable law to provide health care services.
~~any professional person, organization, health facility, or other person or institution licensed by the State to deliver or furnish health services.~~

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Provider Group – A Medical Group, Independent Practice Association, or any other similar organization.

Unplanned Transitions An unexpected transfer between providers, care settings, or levels of care resulting from an acute illness, injury, clinical deterioration, emergency department encounter requiring ongoing treatment, or unanticipated inpatient admission.
~~include any non-elective admission to an acute or long-term care inpatient facility, or any emergency room visit.~~

Terminating Provider – any Provider whose contract with the Alliance is in the process of termination, regardless of which entity initiated the termination process.

Transition - The movement of a member between health care providers, health plans, care settings, or levels of care as the member's health status or service needs change.
~~Movement of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery.~~

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AFFECTED DEPARTMENTS/PARTIES

Member Services
Provider Relations
Contract Management
Health Analytics
Medical Services
Behavioral Health

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

BH-002 Behavioral Health Services
PRV-002 Block Transfers
UM-001 Utilization Management Program
UM- 051 UM Timeliness
UM-058 CoC for New Enrollees with MER
UM-059 CoC for Enrollees Transitioning into Medi-Cal Managed Care

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REVISION APPROVAL HISTORY

10/28/2009, 4/1/2011, 1/25/2012, 9/7/2012, 12/5/2012, 1/9/2013, 1/30/2013, 12/26/2013, 4/25/2014, 7/14/2014, 2/11/2015, 01/10/2016, 04/12/2018, 3/21/2019, 3/19/2020, 5/21/2020, 3/18/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 12/19/2023, 7/17/2024, 9/17/2025, 7/23/2026

REFERENCES

- 2024 Medi-Cal Managed Care Health Plan Transition Policy Guide
- 42 CFR 422.112(b), 438.610 and 438.214(d)(1)

~~2025 Medi-Cal Managed Care Plan Transition Policy Guide~~

- ~~42 CFR 422.112(b)~~
- Assembly Bill 133 (Chapter 143-, ~~Statutes~~Statutes of 2021)
- APL 21-003 Medi-Cal Network Provider and Subcontractor Terminations
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- ~~APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care~~
- ~~APL 23-018 Managed Care Health Plan Transition Policy Guide~~
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
- APL 25-019 Block Transfer
- APL 26-010 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
- APL 26-011 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 26-012~~3-023~~ Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- ~~APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care~~
- Continuity of Care Workflow for Member Services Department
- Continuity of Care Authorization Workflow for Medical Services Department
- CMS Preclusion list
- Health & Safety Code Sections 1371.8, 1373.65, 1373.95, 1373.96 & 14184.208
- Health Omnibus Budget Trailer Bill
- Letter of Agreement Process in Policy and Procedure NTM-CON-002
- Medi-Cal and Group Care Evidence of Coverage
- NCQA Standards

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MONITORING

The Compliance and Utilization Department are responsible for initial and annual delegation oversight of the provision of continuity of care services. At least annually, the UM Department will review this policy annually for compliance with regulatory and contractual requirements.

At least annually, the UM Department will review a statistically significant file review selection to evidence compliance with the CoC processes. Outcomes of the annual delegation oversight and file review are presented to the Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC) annually.

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ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	UM-045
Policy Name	Communication Services - UM
Department Name	Health Care Services
Department Owner	Utilization Management Medical Director
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	10/6/2011
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

PURPOSE

To establish and maintain procedures ensuring that members have timely access to Utilization Management (UM) staff for information about the UM process, authorization of care and status of requests in accordance with DHCS and CMS regulations.

POLICY STATEMENT

All Alameda Alliance for Health (AAH) members and providers can access UM staff when seeking information about the authorization/referral process and/or the UM process (such as criteria used and ability to speak with the reviewer). AAH uses multiple means of communication with members about their rights related to UM, benefits, and care. AAH is committed to providing clear, timely, and accurate communication regarding UM decisions to ensure appropriate access to care in accordance with DHCS and CMS regulations.

PROCEDURE

AAH provides the following communication services for members and providers related to the utilization management (UM) reviews and processes:

1. AAH provides the ability to speak with a UM staff member at least 8 hours a day during normal business hours for inbound calls regarding UM issues. This is provided by utilization review staff that is available by phone during normal business hours of 8 am

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to 5 pm Pacific Time. AAH also offers walk in services to members and providers at its office.

2. After normal business hours inbound calls are received by voice mail and returned the next business day by UM staff. UM staff converts the phones to voice mail at the end of each day and then receive and return the voicemails on the next business day.

~~2.~~3. AAH also provides 24-hour fax capabilities and email for additional inbound ~~e~~communication after normal business hours regarding UM issues. UM staff receives faxes and emails and processes them in accordance with review turnaround times.

~~3.~~4. Staff are available 24 hours, 7 days a week for providers seeking authorizations for post-ER stabilization care. Calls after hours are triaged by AAH clinical staff. Staff are also available on the weekends and holidays during the daytime for assistance with discharge planning and transfers to step down facilities. See UM-015 Emergency Services and Post Stabilization Services for policy and procedure. On- call UM staff shall respond to post-stabilization requests within 30 minutes, as required by DHCS Contract, Exhibit A, Attachment 9.

~~4.~~5. The Alliance maintains communication channels and provides multiple access methods for members and providers.

a. Toll-free telephone number
b. Fax number
c. Secure email address
d. Provider portal
e. Member portal
f. Physical mailing address for written requests.

~~5.~~6. UM staff sends outbound communications in the form of outbound calls, letters confirming UM decisions, emails, and faxes. The communications comply with the requirements for approval and denial letters in terms of content and timing. UM staff use templates to ensure consistency and review customized communications with the UM leadership prior to sending.

a. UM staff are trained on how to coordinate UM decisions for D-SNP members integrating Medicare and Medi-Cal benefits to provide seamless access to care per all of the regulatory bodies.

~~6.~~7. When answering the phone, all UM staff will identify themselves by their name, title and that the caller has reached AAH when initiating or returning calls regarding UM issues. AAH confirms compliance with this through routine monitoring of phone calls performed by the UM Supervisors. Staff that do not comply are coached on effective communication techniques including providing identification. When applicable, members are notified that the call is being recorded for quality assurance purposes.

~~7.~~8. AAH provides telephone numbers to members and providers that they can use to access the UM department and staff. Providers access the UM department directly through 1(510) 747-4540 and members call Member Services at 1(510)747-4567 or at 1(877) 371-2222. Member Services then warm transfers the member to the UM department during normal business hours. This toll-free number is supplied in newsletters, on the website and in enrollment materials to facilitate access to UM staff. AAH also has a toll-free number to member services and member services staff can warm transfer members and providers to the UM department.

~~8.~~9. AAH has a dedicated Member Services phone line for D-SNP: 1.888.882.3767 (888-88ADSNP). The toll-free number is supplied in the Member Handbook, on the web site and in enrollment materials. The number will warm transfer calls to UM Department when appropriate.

~~9.~~10. AAH maintains a 24/7 telephone line for behavioral health clinical triage services. See policy BH-001 and BH –008 for Group Care and D-SNP Lines of business for additional details.

~~10.~~ Specific AAH UM staff communicate directly with members and providers regarding their questions about the UM process. AAH provides access to UM staff at least ~~9~~8 hours a day both directly and through coordination with other areas such as provider services or member services that may refer a caller to the UM Department who has questions about the UM process~~. [illegible]include~~, expedited authorizations, ~~for~~ telehealth. There are ~~or~~ extended timelines as permitted by DHCS and CMS guidance, ensuring members maintain access to care~~. for telehealth or extended timelines as permitted by DHCS and CMS guidance, ensuring members maintain access to care.~~

a. .

~~a.~~i. AAH UM staff consider social determinants of health (SDOH), such as housing, transportation, and food insecurity, when reviewing authorization requests for D-SNP members, ensuring equitable access to care in alignment with CalAIM and CMS health equity goals.

11. AAH offers TDD/TTY and California Relay services for deaf, hard of hearing or speech-impaired members. All UM staff members are trained in how to assist members in accessing these services or UM staff may access these services themselves directly to assist a member. The information regarding the services is listed on the AAH website, in newsletters to members and providers and in enrollment and orientation materials.

12. AAH offers alternative formats for members with visual impairments, such as auxiliary aids and services, giving primary consideration to the member's request of a particular auxiliary aid or service. AAH will offer the alternative formats aids and services to the member and/or a family member, friend, or associate of a member if required by the ADA, including if said individual is identified as the member's authorized representative (AR), or is someone with whom it is appropriate for AAH to communicate (e.g., a disabled spouse of a member). AAH will accommodate the communication needs of all

qualified members with disabilities, including members designated and confirmed ARs, and be prepared to facilitate alternative format requests for Braille, audio format, large print (no less than 20 point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate. AAH will inform a member who contacts AAH regarding an electronic alternative format, that unless the member requests a password protected format, the member will receive notices and information in an electronic format that is not password protected.

a. The member or Authorized Representative (AOR) may contact AAH Member Services, UM or the Case Management department if they wish to use an alternative format. Member Services/UM warm transfers the member to the Case Management department during normal business hours. The Case Management department will assist the member to obtain the alternative format aid or service.

b. AAH will calculate the deadline for a member with visual impairment or other disability requiring provision of written materials in alternative formats, to take action from the date of adequate notice, including all deadlines for appeals and aid paid pending.

13. AAH recognizes the diverse cultural and linguistic needs of our members. AAH hires staff in UM and other areas that are bi-lingual, and a list of those staff and their language abilities is kept in a resource guide for UM staff. If a staff member is not available to assist in translating or speaking with the member in their language, AAH has a contracted interpreter service with qualified interpreter services for threshold languages as defined by DHCS and CMS. UM staff are trained in how to access this service.

14. Information regarding how to access UM staff to discuss UM issues is provided in provider denial notifications, notice of action letters, ~~and~~ coverage determination letters, the provider manual, and member denial of service notifications.
~~14.~~a. There is a direct telephone number listed for any denial, delay, or modification of a requested service for the healthcare professional that is responsible for the UM decision.

15. All members receive a notice of availability of language assistance services and auxiliary aids and services (Notice of Availability) that states the Alliance provides language assistance services and appropriate auxiliary aids and services free of charge.

16. The Member Handbook/Evidence of Coverage is always available to members on the AAH website and will be sent to members upon request. The Handbook describes communication methods available to members regarding all aspects of their AAH membership, such as what services do or do not require prior authorization, how to get all types of care in and out of network, how to access emergency services, second opinions, and sensitive services, the availability of care coordination to assist members to obtain care, and how to access all rights, benefits, and resources available to members.

DEFINITIONS

Accessibility – The extent to which a patient can obtain available services when they are needed. 'Services' refers to both telephone access and ease of scheduling an appointment, if applicable.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

~~1.~~ BH-001 Behavioral Health Services- Medi-Cal
~~2.~~1.
~~3.~~2. BH 008- Behavioral Health Services- Group Care
~~4.~~3. BH-D-001- Behavioral Health Services- DSNP
~~5.~~4. UM-001 UM Authorization Process
~~6.~~5. UM-015 Emergency Services and Post Stabilization

REVISION HISTORY

8/2/2012, 4/21/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 3/19/2024, 9/17/2025, 7/23/26

REFERENCES

- 42 CFR - 422.112(a)(7), 438.10(d), 438.210, 438.206(c)(1)(ii)
- Alameda Alliance for Health Contract with DHCS, Exhibit A, Attachment 13 Member Services, 1. A. 1 (a)
- DHCS APL 21-011: Requirements for utilization management and timely access.
- DHCS APL 22-002: Alternative Format Selection for Members with Visual Impairments.
- DHCS Contract, Exhibit A, Attachment 9 – Access and Availability: Requires plans to maintain procedures for members to obtain necessary health care services in a timely manner.
- DHCS APL 25-005 (Standards For Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats)
- NCQA 2025-2026 Health Plan Standards, UM Standard 3.A.
- Title 28, California Code of Regulations (CCR) 1300.67.2.2: §

MONITORING

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

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Improvement Health Equity/ Utilization Management (QIHE/UM) Committee and Compliance Committee annually.

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POLICY AND PROCEDURE

Policy Number	UM-046
Policy Name	Use of Board-Certified Consultants
Department Name	Utilization Management Department
Policy Owner	Utilization Management Medical Director
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/1/2012
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

Purpose:

~~To establish guidelines for the effective utilization of board-certified physicians in a healthcare setting. To ensure that utilization management decisions are informed by appropriate clinical expertise, particularly in complex or specialized cases, by incorporating board-certified consultants into the UM decision-making process.~~To establish standards governing the use of Board-Certified Consultants and other qualified clinical reviewers in utilization management activities to ensure medical necessity determinations, organizational determinations, and appeals are based on appropriate clinical expertise and comply with Medi-Cal Managed Care, Medicare Advantage (D-SNP), DHCS, CMS, and NCQA requirements.

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Scope:
This policy applies to all healthcare providers and all UM activities, including prior authorizations, concurrent reviews, and retrospective reviews, for services provided to the Alliance Medi-Cal, Group Care and D-SNP members.

The Alliance's authorization process assures timely and efficient access to covered medical services that require authorization from the Plan.

All Organizational Determinations for MediCal, D-SNP, and potential denials for all Lines of Business, issued by the Alliance must be reviewed by the Alliance Chief Medical Officer and/or Medical Director who maintains a current list of Board-Certified consultants to assist
in making medical necessity and appropriateness of care decisions and meet the review needs of the plan. The use of Board-Certified consultants is outlined in Section One (1)

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below.

The Alliance Chief Medical Officer (CMO) maintains a current list of Board-Certified consultants to assist in making medical necessity and appropriateness of care decisions and meet the review needs of the plan.

The list of Board-Certified consultants is reviewed at Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC) and updated at least annually to ensure compliant certification.

All adverse benefit determinations based in whole or in part on medical necessity, appropriateness, setting, level of care, or effectiveness of a requested service shall be reviewed and rendered by a physician or other appropriately licensed clinician acting within their scope of practice and possessing clinical expertise relevant to the member's condition or requested service. A Board-Certified Consultant may be utilized when additional specialty expertise is required.

~~Qualified health professionals supervise review decisions, including service reductions, and a qualified physician, with the assistance of Board-Certified Consultants when needed, reviews and signs all denials that are made, whole or in part, on the basis of medical necessity.~~

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Board certified consultants may also be engaged in the following circumstances:

- When the clinical aspects of a case fall outside the expertise of available utilization management and medical director staff.
- When standard medical necessity criteria do not adequately address the specifics of a case.
- ~~When a provider requests a peer-to-peer discussion regarding a UM decision.~~When a provider requests a peer-to-peer discussion regarding a UM decision. Peer-to-peer consultations are intended to facilitate clinical discussion and information exchange and do not replace member appeal rights, provider dispute rights, Independent Medical Review rights, or Medicare reconsideration rights

All board certified consultants hold an active unrestricted license to practice medicine. The Alliance maintains business associate agreements with the contracted Independent Review Organization (IRO) or consultant, allowing for disclosure of protected Health information (PHI).

The Alliance will ensure that the IRO performs verifications through their credentialing and recredentialing process that the consultant is licensed and board-certified in the appropriate specialties.

PROCEDURE

A. **When to use a Board-Certified Consultant**
Board Certified Consultants should be used whenever a reviewer of the appropriate specialty is not available to make a decision on a denial or appeal. These circumstances are described below.

1. **Independent Medical Review** - When the Medical Director reviewer is unable to apply medical necessity and regulatory guidelines (UM-001) for the Medical Director medical necessity review, particularly for non-covered benefits that require medical necessity review. Board Certified consultants will provide an independent medical review with medical necessity recommendations based on peer reviewed published journals, national organization guidelines, and expert opinion.

2. **High Complexity or Specialized Procedures and Services** - Board Certified Consultants should be used to review highly complex cases or procedures when the facts are not clearly defined and there are alternative decisions that may be made based upon assessment of the clinical condition
These procedures or services require the review of a professional in the same or similar specialty to the physician performing the procedure and the expertise is not readily available within the network of credentialed providers to give a nonbiased and evidence-based review

3. **Insufficient Levels of Certification** - Board-Certified Consultants should be used when the physician performing the procedure or service is highly credentialed or board certified and internal review resources are not similarly credentialed or certified.

4. **Conflict of Interest** - Board Certified Consultants should be used if available internal reviewers have established personal or professional conflicts of interest.
    - ~~4.~~ Board-Certified Consultants, Medical Directors, and reviewers shall be free of financial incentives, compensation arrangements, or conflicts of interest that could influence utilization management decisions.

5. Situations where there is disagreement between the treating provider and the health plan Medical Director or a Behavioral Health Medical Director about a treatment plan or a medical necessity appeal decision.

6. Board-Certified Consultants may be utilized during appeal review when specialized clinical expertise is required or when regulations require review by a clinician with expertise appropriate to the member's condition. Appeal reviewers shall not have participated in the original adverse determination.
    - The Alliance shall not utilize consultants who are excluded, suspended, debarred, precluded, or otherwise ineligible to participate in Medicare, Medi-Cal, or other federal health care programs. Verification shall occur through applicable federal and state exclusion and sanction databases.
7. For D-SNP members, utilization management decisions and appeals shall comply with applicable Medicare Advantage requirements, including requirements pertaining to clinical expertise, independence of review, timeliness, and member notification.

~~6. To review Appeals, when necessary~~

B. **How to Use a Board-Certified Consultant**

1. The Alliance contracts with Advanced Medical Reviews (AMR) to provide

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independent medical review services, upon request, to support the inpatient and outpatient medical necessity service authorization decision process.

a. Requests for an AMR Board Certified consultant review are submitted online via the AMR secure client portal

b. Appropriate Alliance staff receive training on how to contact AMR and use board certified consultant services.

2. The Alliance will take the following steps to ensure the consultant's appropriate involvement once it is determined that the use of a Board-Certified consultant is necessary:
   a. Access the AMR web portal and submit a request for the Board-Certified consultant review.
   b. Attach, fax or email necessary case information and identify the specific questions to be addressed. Receive decision and supporting explanations within 24 hours of their receipt of initial case information. The consultant will use the latest available knowledge to review the current treatment plan, define standards of care and identify deviations from or adherences to standards of care and recommend a plan.

DEFINITIONS / ACRONYMS

Board Certified: Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

Board Eligible: Describes a physician who is eligible to take the specialty board examination by virtue of being graduated from an approved medical school, completing a specific type and length of training, and practicing for a specified amount of time.

Independent Review Organization (IRO): An entity that conducts independent external medical or behavioral health reviews of medical necessity determinations and adverse health care treatment decisions.

Organization Determination: Any determination made by a health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a practitioner other than the health plan that the enrollee believes are covered under the plan, or, if not covered under the plan, should have been furnished, arranged for, or reimbursed by the health plan;
- The health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the health plan;
- Discontinuation of a service if the enrollee believes that continuation of the services is medically necessary; or

- Failure of the health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

AFFECTED DEPARTMENTS / PARTIES

All Alliance Departments~~.~~

RELATED POLICIES AND PROCEDURES

1. PDR-001 Provider Dispute Resolution Mechanism
2. QI-104 Potential Quality of Care Issues (PQIs)
3. UM-001 Utilization Management
4. UM-046 -Attachment A
5. UM-001 Utilization Management

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

AMR Board Certified Consultants List

REVISIONAPPROVAL HISTORY

3/30/2012, 8/29/2012, 10/24/2012, 4/11/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 9/18/2023, 9/18/2024, 9/17/2025, 7/23/2026

REFERENCES

- 42 CFR §438.210 – Coverage and Authorization of Services.
- 42 CFR Part 438 Subpart F (Appeals and Grievances).
- DHCS APL 21-003 – Medi-Cal Network Provider and Subcontractor Terminations (for exclusion/sanction screening).
- Current NCQA Health Plan Accreditation UM Standards rather than any 2014 NCQA references.

~~2025 NCQA Standards A. UM 4- UM 7 (Use of Board-Certified Consultants)~~

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MONITORING

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

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POLICY AND PROCEDURE

Policy Number	UM-048
Policy Name	Triage & Screening Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	3/31/2015
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

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POLICY STATEMENT

Alameda Alliance for Health ("Alliance") arranges for triage and screening services available by telephone to members 24 hours per day, 7 days per week. The plan establishes a consistent, effective, and compliant approach to patient triage and screening. Telephone triage or screening services are provided in a timely manner appropriate for the requesting member's condition.

The Alliance arranges for and monitors the availability of ~~T~~triage and screening services ~~are~~ provided by through its contracted provider ~~the Alliance by the telephone medical advice services and the Alliance's primary care~~network, behavioral health services network and nurse advice line services ~~and mental health provider network~~. When the Alliance uses its primary care and mental health network to provide triage services it requires its providers to maintain a procedure for triaging or screening member telephone calls.

U~~The plan has u~~nlicensed personnel may gather demographic or administrative information and relay standardized questions to ~~staff who ask questions on behalf of a~~ licensed staff person. ~~in order to help ascertain the condition of a member in order to refer the member to the adequate licensed staff.~~ Unlicensed Staff ~~Though~~ shall not ~~under no circumstances does the Alliance allow unlicensed staff to~~ answer questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional.

PROCEDURE

Alameda Alliance for Health is contingent on its contracted provider network to provide triage services to its members. Primary care providers and mental health care providers must provide triage and screening services 24 hours a day, 7 days a week. Triage and screening responses shall occur within ~~The provider's wait time for triage services is required to not exceed~~ thirty (30) minutes or less consistent with applicable DHCS, DMHC and CMS access standards. Patients will be sorted based on the severity of their condition and determining the priority of

their treatment according to clinical urgency. Triage systems shall be standardized and evidence based in compliance with CMS regulations and DHCS requirements.

A. Provider Triage and Screening Procedures

The providers must maintain the following procedures for triage and screening member telephone calls:

1. Employment, during and after hours, of a telephone answering machine and/or an answering service and/or office staff.
2. Notice to caller regarding length of wait for a return call from the provider.
3. Notice to caller regarding how they may obtain urgent or emergency care including, if applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

B. Nurse Advice Line

For cases when the providers are unable to meet the time-elapsed standards, the Plan provides members the Alliance's nurse advice line to call as an alternative triage and screening service arrangement. Providers who are unable to provide triage and screening services are required to inform members about the Alliance's nurse advice line information. Interpreter services, Telecommunications Relay Services (TRS),TTY/TTD services, alternative formats, and oral interpretation services are available at no cost to members in accordance with federal and state language access requirements and Alliance policy ~~The nurse advice line provides interpreter services in threshold languages that are identified by DHCS within the Alliance's Service Area, and by the Alliance through membership assessments. See~~ *CLS-008 Member Assessment of Cultural and Linguistic Needs* for more details.

The Alliance uses a nurse advice line to handle any calls that cannot be answered within the thirty (30) minute threshold for its Medi-Cal, Group Care (IHSS) and D-SNP members. The phone number for the nurse advice line is included in the EOC and Alliance website. Members may access the nurse line by calling the customer service line, located on the membership card, and following the appropriate prompts. AAH has a dedicated Member Services phone line for D-SNP: 1.888.882.3767 (888-88ADSNP). The toll-free number is supplied in the Member Handbook, on the web site and in enrollment materials.

The Alliance monitors the triage standards for the Nurse Advice Line to ensure that the line provides 24 hours per day, 7 days per week triage/screening services in a timely manner appropriate for the members' condition, and that the waiting time does not exceed 30 minutes. This is done by reviewing quarterly reports on Nurse Line processes, including timeliness of responding to calls.

For behavioral health care needs, AAH provides triage and screening services for members and providers. See policy BH-001 Behavioral Health Services for Medi-Cal. BH-008 for Group Care, BH-D-00~~X~~1 for D-SNP and MBR-062 MS Referrals and Triage. ~~-~~

C. Member Distribution

The Alliance provides members with information about the availability of triage and screening services and how to obtain the services in its Evidence of Coverage (EOC). Information regarding triage and screening services is provided through member handbooks, Evidence of Coverage documents, provider directories, member materials and

the Alliance website in accordance with applicable regulatory requirements. ~~The Alliance's EOC is provided to members upon enrollment and annually thereafter. The Alliance's website also provides information on triage and screening services. The Providers are provided with the triage and screening requirements as a part of the orientation when contracted with the Alliance, and in the Provider Manual posted on the Alliance's website.~~

DEFINITIONS / ACRONYMS

Triage- the assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care for the purpose of determining the urgency of the member's need of care.

Triage waiting time – the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Member Services
Case Management
Behavioral Health
Quality Management
Provider Services
Compliance

RELATED POLICIES AND PROCEDURES

QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-114 Monitoring Access and Availability Standards
QI-115Access and Availability Committee
QI-116 Provider Appointment Availability Survey
QI-117 Member Satisfaction Survey
QI-118 Provider Satisfaction Survey
CLS-008 Member Assessment of Cultural and Linguistic Services
CLS-009 CLS Program – Contracted Providers
CLS-011 CLS Program- Compliance Monitoring
PRV-003 Provider Network Capacity Standards
BH-001 Behavioral Health Services for Medi-Cal
BH-008 Behavioral Health Service for Group Care
BH-D-001 Behavioral Health Service for D-SNP
MBR-062 MS Referrals and Triage

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

01/10/2016, 12/15/2016, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 7/17/2024, 9/17/2025, 7/23/2026

REFERENCES

DHCS Contract Exhibit A, Attachment 9 Access and Availability
Title 22 CCR §53851 DHCS Timely Access to care standards
~~Title 22, CCR, §53855, Requirements for appointment scheduling and triage~~
Title 28, CCR, §1300.67.2, Accessibility of Services
Title 28, CCR § 1300.67.2.2 Timely Access to Non-Emergency Health Care Services
42 CFR §482.12, ~~Governing body responsibilities for quality of care~~,§438.206 , §438.10 , §422.112(a)(7)
Health & Safety Code §1367.03

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MONITORING

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

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POLICY AND PROCEDURE

Policy Number	UM-050
Policy Name	Tracking and Monitoring of Services Prior Authorized
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	3/24/2016
Administrative Oversight Committee Date	~~9/17/2025~~TBD

Purpose:
This policy establishes procedures for the systematic tracking and monitoring of healthcare services subject to prior authorization (PA) requirements. It ensures compliance with CMS and Medicaid services regulations for PA and safeguards against improper utilization**.**

Scope:
All clinical and administrative staff involved in requesting and processing healthcare services that require PA.

POLICY STATEMENT

A. The Alliance maintains a specialty referral system to track and monitor referrals requiring prior authorization. The system includes authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system includes non-contracting providers.

B. Services and specialist referrals that may require prior authorization include:
   - Out of network (OON) specialist referrals
   - Some In-network specialists

C. Services which require PA are subject to change annually, or more often as needed, following approval from the Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC). The list will be based on Medicare Advantage and Medicaid requirements, CMS national coverage determinations (N~~D~~CD), local coverage determinations (LCD) and Medicare/Medi-~~-~~Cal benefit policy manual guidelines.

D. The Alliance ensures that all contracting health care practitioners are aware of

the referral processes and tracking procedures.

E. The member's Primary Care Provider (PCP) or treating provider arranges and coordinates any specialty referrals or services which may require prior authorization.

F. A monitoring process is in place to ensure those authorized services are completed in a timely manner.

G. Prior authorization status will be monitored continuously to ensure compliance with regulatory requirements.

H. Emergency services do not require prior authorization.

PROCEDURE

A. The Alliance Utilization Management Program has an established tracking system for prior authorizations (PA) authorized, denied, deferred or modified for members assigned to a Directly Contracted Provider (DCP).

B. The Alliance captures all inpatient and outpatient authorization requests for members assigned to a DCP in the Alliance Clinical Information Management system. Refer to Policy and Procedure UM-057 Authorization Service Requests process. The following information, at a minimum, is tracked:

1. Authorization tracking number
2. Member Demographics
3. Line of Business (Medi-Cal, D-SNP, Group Care)
4. Service(s) requested
5. Diagnosis
6. Provider
   - Requesting Provider
   - Rendering Provider
7. Decision Maker
   - Clinical Reviewer/ Medical Director
8. Decision and notification timeliness compliance
9. Level of Urgency Routine, Expedited, Retro)
10. Expedited Request Justification (If Applicable)
11. Dates
    - Dates of Service Authorized
    - Request Date & Time
    - Decision Date & Time
    - Notification Date & Time
12. Status of Authorization (Approved, denied, partial approval, deferred)
13. Reason for denial
14. Reason for modification
15. Appeal Rates and outcomes

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16. Provider appeal status

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ember appeal status

~~1. Service(s) requested~~
~~1. Standard vs expedited~~
~~• Date of request~~
~~2. Date(s) of service(s) requested~~
~~3. Diagnosis~~
~~4. Requesting provider~~
~~5. Rendering provider~~
~~6. Date(s) of service(s) authorized~~
~~7. Member demographics~~
~~8. Authorization tracking number~~
~~9. Status of authorization (approved, denied, partially approved)~~
~~10. Reasons for denials~~

~~11. Appeal rates and outcomes~~

C. HealthCare Analytics runs a report monthly using data from the Clinical Information System to track, at a minimum, the following:
   1. Authorization ~~turn-around times~~decision timeliness
   2. Notification Timeliness
   3. Authorization Volume
   4. Approval Rates
   5. Denial Rates
   ~~1.~~ Modification Rates
   ~~2.~~6. ~~Authorization decision approved,~~ partial approved~~, denied,~~ and deferred -
   ~~3.~~ Prior authorizations never utilized
   7.
   8. ~~4.~~ Authorizations for specialist referrals, including out-of-network
   9. Overturn rates and appeal outcomes

D. A monitoring report is in place to ensure those services authorized are utilized within the authorized time duration. The monitoring report identifies all authorizations without a corresponding claim by the mid-cycle of the authorization duration and 90 days following the end of the authorization period.

E. On a monthly basis, the monitoring report for unused authorizations is reviewed by the assigned Alliance -UM~~UM~~ Leadership.

~~E. Specialist.~~

F. For unused authorizations within 60 calendar days of the initial authorization, a reminder letter will be sent to all the members with an authorized service without a corresponding claim. The letter is to remind the members to obtain the authorized services before authorization expiration.

   1. A monthly report with applicable information is sent securely to our mail vendor to send out all letters. A confirmation report for each member is sent from the vendor to the Alliance for tracking
   2. A copy of reports and confirmation is maintained by the UM Manager.

G. For unused authorizations that remain unused greater than 90 calendar days from the

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end of the authorization period with no corresponding claim, a reminder letter will be sent to the Member and/or Member's Representative and Requesting Provider informing them the authorization has expired and, if needed, how to obtain a new authorization.

H. Expiration Monitoring
   1. Weekly reports of authorizations expiring within 30 days
   2. For services not yet provided, ~~determine if service is still needed~~the Alliance will assess whether the authorized service remains medically necessary, whether the service has been obtained, and whether a renewal request is clinically indicated
   3. Initiate renewal requests at least 14 days before expiration

Monitoring and Access

Every quarter, the monitoring report will be reviewed and presented to the UM Subcommittee to evaluate whether there are access constraints for certain providers and specialties. In addition, if there are certain members that have 100% open and unused authorizations, this may warrant case management to help address any Social Determinants of Health (SDOH) that may be causing barriers to care and to help coordinate the member's care. The Alliance may analyze authorization utilization data by race, ethnicity, language, disability status, age, geographic region and other health equity factors to identify disparities in access to authorized services.

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated utilization management responsibilities will also need to demonstrate compliance with applicable DHCS, CMS, NCQA, contractual, and Alliance utilization management requirements through ongoing oversight, monitoring, auditing, reporting and corrective action process. ~~comply with the same standards.~~ Refer to CMP-400~~019~~ for monitoring of delegation oversight.

DEFINITIONS/Acronyms:

Delegated entity: entity the Alliance contracts with to perform utilization management functions.
Directly Contracted Provider (DCP): provider directly contracted with the Alliance; the Alliance manages the care for members with a PCP directly contracted with the Alliance.
Medical Necessity: services or supplies that are needed for the diagnosis or treatment of a medical condition that meet the standards of good medical practice and not for convenience.
Out of Network (OON): provider not contracted with the Alliance.
Prior Authorization: A process where approval for coverage of a service or treatment must be obtained from a payor before the service is provided
Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC): committee comprising of medical services.
Utilization Management Subcommittee: monthly committee comprising of management from UM, pharmacy, and appeals department to discuss utilization metrics; reports up to QIHE/UMC.

AFFECTED DEPARTMENTS/PARTIES

HealthCare Analytics
Information Technology
-Utilization Management
Grievance and Appeals
Delevation Oversite

RELATED POLICIES AND PROCEDURES

- BH-001, Behavioral Health Services, Medi-Cal
- BH-008, Behavioral Health Services, Group Care
- BH-D-001, Behavioral Health Services, D-SNP
- CMP-400~~019~~ Delegation Oversight
- UM-057 Authorization Service Request Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

3/24/2016, 12/15/2016, 04/16/2019, 3/19/2020, 5/21/2020, 5/15/21, 5/20/2021, 6/28/2022, 9/18/2023, 7/17/2024, 9/17/2025, 7/24/2026

REFERENCES

DHCS Managed Care Contract (UM reporting and monitoring requirements)
CMS Prior Authorization/ interoperability requirements
NCQA UM Standards regarding monitoring of decision making and access to care. ~~None~~

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MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC) and Administrative Oversight Committee annually.

POLICY AND PROCEDURE

Policy Number	UM-051
Policy Name	Timeliness of UM Decision Making and Notification
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/10/2016
Administrative Oversight Committee Approval Date	~~6/17/2026~~TBD

POLICY STATEMENT

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

POLICY

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

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

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

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

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

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

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

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

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

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

   3. Alameda Alliance informs providers, via the provider manual and website that Acute Inpatient, Post Stabilization or Urgent Discharge requests submitted after normal business hours should be made by calling UM On-call line 510-326-5271.

E. E. Alameda Alliance has a process for determining urgency (expedited request status) following **42 CFR §422.570** definition of urgent (expedited) and may deescalate the request if it is determined that is does not meet the definition of urgent (expedited).

F. Concurrent Review
   1. Care shall not be discontinued until the treating provider has been notified of the Plan's decision for denial and a plan of care has been agreed upon by the treating provider which is appropriate for the medical needs of that patient within 24 hours per Section 1367.01(h)(3).
      a. The Alliance refers to Policy UM-052 Discharge Planning to Lower Level of Care for alignment with the process for creation and implementation of a plan for a safe discharge and the potential utilization of Administrative Days.

PROCEDURE

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

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

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

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

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

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

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

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

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

3. For requests received by fax or portal that are outside of normal business hours the date of receipt is logged as the same day/time the fax or portal submission is received.

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

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

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

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

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

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

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

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

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

D. MONITORING

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

DEFINITIONS / ACRONYMS

A. **Centers for Medicare and Medicaid (CMS)** a federal agency within the U.S. Department of Health and Human Services that administers the nation's major healthcare programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Health insurance marketplace.

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

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

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

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

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

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

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

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

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

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

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

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

AFFECTED DEPARTMENTS/PARTIES

Utilization Management Department (UM/ LTSS)

Compliance Department
Pharmacy Department

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

11/10/2016, 4/12/2018, 4/16/2019, 5/21/2020, 3/18/2021, 3/22/2022, **02/21/2023, 12/18/2024, 12/29/2025**, **5/20/2026, 6/17/2026, 7/15/2026**

Blue = material updates

REFERENCES

1. 2025 UM Standards; UM 5, Element A: Notification of Nonbehavioral Healthcare Decisions
2. 42 CFR § 422.631, 422.568(b)(2), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), 422.590(c), 422.590 (e), 422.631(a) and 422.633(f))
3. CA Health and Safety Code sections 1367.01(h)(1) through (5)
4. DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care
5. DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 2 (A), (B), (F), (G), and (I); Item 3 (A) through (J)
6. EAE SMAC (2025 Boilerplate, AIP D-SNP Model Materials)
7. MMCD Policy Letter 12-005 Enteral Feedings
8. NCQA UM Standards Factor 1A sections 1-4.
9. Title 22 CCR Section 53855 (a) or any future amendments thereto.

Policy Number	UM-055
Policy Name	Palliative Care
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Line(s) of Business	MCAL, D-SNP
Effective Date	01/01/2018
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

Purpose:

This policy establishes guidelines for the provision of palliative care services in alignment with Medicare and Medicaid services (CMS)

Scope:

This policy applies to healthcare providers, staff and departments involved in delivering palliative care services within Alameda Alliance for Health (Alliance)

POLICY STATEMENT

The Alliance is committed to providing high-quality palliative care services. Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care manages symptoms, addresses psychosocial needs, and supports patients and their families through the course of illness, regardless of prognosis.

Pursuant to Senate Bill (SB) 1004 and Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020, and under Alameda Alliance for Health's (Alliance) contract relative to the provision of the Medi-Cal for Kids/ Teens (also known as Early Periodic Screening, Diagnostic and Treatment [EPSDT]) services, the Alliance authorizes palliative care services to its members when those services are medically necessary. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the Alliance's contracts and does not affect a member's ability to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care.

Hospice care is both a Medi-Cal and a D-SNP benefit that serves terminally ill members. It consists of interventions that focus primarily on pain, stress and symptom management rather than a cure or the prolongation of life. To qualify for hospice care, a Medi-Cal member must have a life expectancy of six months or less. Further information regarding Medi-Cal hospice care is available in APL 13-014, titled "Hospice Services and Medi-Cal Managed Care," including any future iterations of this APL.

In Dual Eligible Special Needs Plans (DSNPs), the hospice benefit is not managed by the DSNP itself. Instead, this benefit is carved out and provided through Medicare Fee-For-Service (FFS). This means that the responsibility for hospice care falls under Medicare FFS, rather than the DSNP.

Key Points:

- **Carved Out Benefit**: The hospice benefit is specifically excluded from the DSNP's coverage responsibilities.
- **Medicare Fee-For-Service**: Hospice services are administered and funded through Medicare FFS, ensuring that members receive the necessary end-of-life care directly from Medicare.
- **Coordination**: While the DSNP does not manage hospice care, it may still coordinate with Medicare FFS to ensure seamless transitions and continuity of care for members requiring hospice services.

This arrangement allows DSNPs to focus on other aspects of care while ensuring that members receive comprehensive hospice services through Medicare FFS.

Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if they meet the hospice eligibility criteria. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care under the Section 1915(c) Home and Community Based Services waiver, known as the Pediatric Palliative Care waiver, or concurrent care under Section 2302 of the Patient Protection and Affordable Care Act (ACA). See APL 13-014, California Children's Services Numbered Letter 06-1011, and Managed Care Policy Letter #11-004.

Procedure

A. Eligibility Criteria

As outlined in APL 18-020, Alliance adopts the DHCS' SB 1004 Palliative Care Policy for the minimum eligibility criteria for palliative care and will authorize palliative care services when medically necessary for members who meet the eligibility criteria.

Members of any age are eligible to receive palliative care services if they meet all the criteria outlined in Section B. below, and at least one of the five requirements outlined in Section C. Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in Section D below, consistent with the provision of Medi-Cal for Kids/ Teens (also known as Early Periodic Screening, Diagnostic and Treatment (EPSDT)) services.

D-SNP members meeting the minimum eligibility criteria shall have access to palliative care services regardless of whether Medicare or Medi-Cal is the primary payer. The plan shall coordinate the Medicare and Medi-Cal benefits.

B. General Eligibility Criteria:

1. Member must meet all criteria listed in section A, and at least one of the criteria listed in B-E.
    a. The member is likely to, or has started to, use the hospital or emergency department to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
    b. The member has an advanced illness, as defined in the disease specific eligibility section below, with appropriate documentation of continued decline in health status, and is not eligible for hospice (adult only; 21 years old or older) or declines hospice enrollment.
    c. The member's death within a year would not be unexpected based on clinical status.
    d. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
    e. The member and, if applicable, family member/ member-designated support person, agrees to:
        i. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/ palliative care instead of first going to the emergency department; and
        ii. Participate in Advance Care Planning discussions

C. Disease Specific Eligibility Criteria

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
    a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and
    b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)
    a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
    b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
    a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone.
    a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    b. The member has ascites, subacute bacterial peritonitis, hepatic

encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or

c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

5. Advanced Dementia/ Alzheimer's Dementia: Must meet four (4) of five (5) criteria:
   a. Profound memory deficits
   b. Functional impairment (ADL dependencies)
   c. Minimal communication
   d. Decreased oral intake and/or significant weight loss in last six (6) months.
   e. Malnutrition

6. Progressive Neurological conditions
   a. Difficulty breathing, eating or drinking
   b. Respiratory muscle weakness
   c. Nutritional impairment
   d. Stroke patients with poor KPS (Karnofsky Performance Status) or PPS (palliative performance scale) score

7. End stage renal disease

8. Other life-limiting conditions causing significant symptom burden

D. Pediatric Palliative Care Eligibility Criteria

1. Must meet (a) and (b) listed below. Members under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.
   a. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
   b. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
      i. Conditions for which curative treatment is possible, but may fail (e.g., advanced, or progressive cancer or complex and severe congenital or acquired heart disease); or
      ii. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
      iii. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
      iv. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

2. If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.
   a. AAH has a process to identify members who are eligible for palliative care, including a provider referral process. AAH will periodically assess the member

for changes in the member's condition or palliative care needs. AAH may discontinue palliative care that is no longer medically necessary or no longer reasonable.

3. For children who have an approved CCS-eligible condition, CCS remains responsible for medical treatment for the CCS-eligible condition, and AAH is responsible for the provision of palliative care services related to the CCS-eligible condition. AAH is also responsible for the provision of hospice services for pediatric members.

E. Palliative Care Services

1. When a member meets the minimum eligibility criteria for palliative care, AAH will authorize palliative care without regard to age. Palliative care includes, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

    1. Advance Care Planning: Advance care planning for members- includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally- recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life- Sustaining Treatment (POLST) forms. Please refer to the section on advance care planning in the Provider Manual for further details.

    2. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advanced care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:
        a. Treatment plans, including palliative care and curative care.
        b. Pain and medicine side effects
        c. Emotional and social challenges
        d. Spiritual concerns
        e. Patient goals
        f. Advance directives, including POLST forms.
        g. ~~Legally recognized~~Legally recognized decision maker

Plan of Care: A plan of care should be developed with the engagement of the member and/or the member's representative(s) in its design. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care. The plan of care must not include services already received through another Medi-Cal funded benefit program (e.g., CCS Program).

3. Palliative Care Team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual

needs of a member and of the member's family, and/or legally- recognized decision maker and are able to assist in identifying the member's sources of pain, and discomfort.

This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members provide all authorized palliative care. DHCS recommends that the palliative care team include but is not limited to the following team members: a Doctor of Medicine or osteopathy (Primary Care Provider if MD or DO); a registered nurse; a licensed vocational nurse or nurse practitioner (NP) (Primary Care Provider if NP); and a social worker. DHCS also recommends that there is access to chaplain and/or spiritual care provider services as part of the palliative care team. Chaplain services provided as palliative care are not reimbursable through the Medi-Cal program.

4. Care Coordination: A member of the palliative care team provides coordination of care, ensures continuous assessment of the member's needs, and implements the plan of care.

5. Pain and Symptom Management: The member's plan of care includes all services authorized for pain and symptom management. Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address a member's pain, and other symptoms.

6. Mental Health and Medical Social Services: Counseling and social services must be available to the member to assist in minimizing stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate.

   Provision of medical social services does not duplicate specialty mental health services provided by Alameda County Behavioral Health Care Services (ACBHCS). Furthermore, provision of medical and social services does not change AAH's responsibility for referring to, and coordinating with, ACBHCS, as delineated in APL 17-018 "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services," including any subsequent revisions.

2. AAH has a process to determine the type of palliative care that is medically necessary or reasonable for eligible members. AAH has an adequate network of palliative care providers to meet the needs of members.

3. AAH may, at its discretion, authorize additional palliative care not described above. Examples of additional services offered by some community-based palliative care programs include a telephonic palliative care support line that is separate from a routine advice line and is available 24 hours a day/7 day a week, and expressive therapies, such as creative art, music, massage and play therapy, for the pediatric population.

F. Providers/ Network

1. Palliative care services may be authorized in the hospital, as part of the inpatient care treatment plan, outpatient (primary care, specialty care clinics), or by community-based settings, such as home health teams, or hospice entities. The Alliance offers a network of palliative care services to its members through various provider types and utilizes qualified providers who comply with the existing Medi-Cal requirements.

2. The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on the setting and needs of the members as long as the provider complies with the existing Medi-Cal requirements.

3. The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

4. The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website, Member Handbook, Member Services, Case Management, and member education materials.

G. Referrals and Authorizations

Referrals for palliative care consultation may be made by the following:

1. Attending physicians
2. Advanced practice providers
3. Nursing staff
4. Case Managers
5. Patients or family members with a physician order
6. The Alliance identifies members eligible for palliative care by the following:
    a. Screening for palliative care eligibility in basic Case Management, Complex Case Management, ECM providers, CBAS designees, Transitions of Care, and 2024 Managed Care Plan Transition for Special Populations and CalAIM Dual Eligible Special Needs Plan Policy Guide.
    b. Referrals from network providers, members/ family members/ legal-recognized decision-maker, including through case management. concurrent utilization review, and the general authorization process.
    c. Population Health Management: Analysis of member data

H. Authorizations:

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1. Palliative care services follow the general authorization process outlined in the Utilization Management (UM) policy and procedure UM-001 and UM-057 Authorizations Process. Authorizations for palliative care services are reviewed as outlined in UM-001 UM Authorizations Process and meet the timeliness standards as outlined in policy and procedure UM-051 Timeliness of UM Decisions.

2. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity.

3. Referral and care coordination for palliative services will be provided to the member within the time or distance access standard requirements.

4. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider manual, provider newsletters, educational materials and via the Alliance's website.

I. Grievance and Appeals

1. Member complaints related to the provision of palliative care services and authorization process are processed through the Alliance's Grievance and Appeals system in a manner consistent with grievance and appeals requirements set forth in APL 17-006 Grievance and Appeal Requirements and Revised Notice Templates

   and "Your Rights" Attachments. The process is further described in policy and procedure G&A- D-001 Grievances and Appeals System Description.

2. The Alliance monitors and collects palliative care enrollment, provider, and utilization data to report to DHCS as specified. The Alliance ensures that their delegates comply with all applicable state and federal law and regulations and other contractual requirements as well as DHCS' guidance, including APLs. AAH communicates these requirements to all their delegated entities and subcontractors.

Delegation Oversight

The Alliance adheres to applicable state and federal laws and regulatory requirements, contractual requirements, other DHCS guidance, and accreditation standards for delegates and subcontractors. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS/ ACRONYMS

Hospice Care - defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.

2024 MCP Transition - Refers to changes to the Medi-Cal Managed Care Plans (MCPs) operating in specific counties slated to take effect on January 1, 2024, as a result of county-level Medi-Cal model change, changes to commercial MCP contracting, and the Kaiser direct contract.

Palliative Care - patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Interventions focus primarily on reduction and abatement of pain, stress, and other disease-related symptoms rather than interventions aimed at investigation and /or cure or prolongation of life. See Health and Safety Code §1339.31(b).

Special Populations - Members most at risk for harm from disruptions in care or who are least able to access Continuity of Care protections by request or who are identifiable in DHCS data or Previous MCP's data.

Terminally ill - defined in:

1. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.
2. CA Health and Safety Code§ 1368.l(a) as an incurable or irreversible condition that has a high probability of causing death within one year or less.

Transitions of Care (Population Health Management)- ensures Members are supported from the start of the discharge planning process, through their transition, until they have been successfully connected to all needed services and supports.

Interdisciplinary Group (IDG): A team of qualified professionals who collectively provide palliative care services to patients and their families

Interdisciplinary Care Team (ICT): A team of qualified professionals. For D-SNP ICTs will have a trained dementia care specialist on the team

Plan of Care: A comprehensive, individualized care plan developed by the interdisciplinary group in consultation with the patient's provider, the patient, patient representative and primary caregiver.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Claims
Compliance
Provider Relations and Contracting

RELATED POLICIES AND PROCEDURES

CMP-400 for monitoring of delegation oversight
G&A-D-001 Grievances and Appeals System Description
UM-001 Utilization Management

UM-008 Coordination of Care - California Children's Services
UM-011 Coordination of Care - Hospice and Terminal Illness
UM-051 Timeliness of UM Decisions
UM-057 Authorizations

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISIONAPPROVAL HISTORY

1/04/2018, 3/21/2019, 5/21/2020, 5/20/2021, 6/28/2022, 10/19/2023, 12/18/2024, 9/17/2025

REFERENCES

- 2026 D-SNP Policy Guide
- 42 CFR 418
- CALAIM: Population Health Management (PHM) Policy Guide, May 2024
- California Children's Services, #06-1011
- CMS Quality Reporting Program Measure Specifications User Manual
- DHCS APL13-014 Hospice Services and Medi-Cal Managed Care
- DHCS APL 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
- DHCS APL 18-020 Palliative Care and Medi-Cal Managed Care
- DHCS APL 21-011 Grievance and Appeal Requirements and Notice and "Your Rights" Templates
- DHCS APL 26-0022 ~~006~~ Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services
  - ~~DHCS Managed Care Policy Letter 11-004.~~
- DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide, V7
- DHCS D-SNP Policy Guide 2026~~5~~
- DHCS Palliative Care Fact Sheet for D-SNPs
- DHCS D-SNP Quality and Data Reporting Requirements
- Medi-Cal Provider Manual "Evaluation and Management (E&M)
- Patient Protection and Affordable Care Act (ACA), Section 2302.
- Senate Bill 1004 Palliative Care
- Welfare and Institute Code (WIC) Section 14132.75

MONITORING

This policy will be reviewed on an annual basis to ensure it complies with regulatory and contractual requirements.

POLICY AND PROCEDURE

Policy Number	UM-057
Policy Name	Authorization Service Request
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Utilization Management Director
Lines of Business	MCAL, IHSS, D-SNP
Effective Date	11/02/2004
Administrative Oversight Committee Approval Date	~~05/20/2026~~TBD

POLICY STATEMENT

Alameda Alliance for Health (Alliance) maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.

The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to **CA Health and Safety Code §1367.01, 1367.665, 1374.141**, and **42 CFR 438.900(d)** and **42 CFR Subpart K**~~.~~

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A. The Alliance develops, reviews, and approves at least annually, lists of services that are exempt from prior authorization, services rendered by the Alliance direct-network that do not require authorization, services that are appropriate for auto-authorization, and services that require prior authorization and clinical review for medical necessity specific to each Line of Business (LOB).

B. The Alliance shall communicate to all contracted health care practitioners the procedures, treatments, and services that require authorization and the procedures and timeframes necessary to obtain such authorizations.

1. Communication shall include the data and information the Alliance uses to make determinations (e.g., UM criteria, patient records, conversations with appropriate physicians) that guide the UM decision-making process.
2. The Alliance publishes its Clinical Practice guidelines on the Alliance website for use

by any contracted or non-contracted provider. These guidelines cover both clinical care and Preventive Care:

i. alamedaalliance.org/providers/provider-resources

ii. alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/

3. The Alliance provides written information on criteria and evidence-based practice guidelines used for decision making in accordance with the UM-054 Notice of Action Policy for both contracted and non-contracted providers.

PROCEDURE

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A. UM Parity

1. The Alliance ensures that there is parity between the provision of medical/surgical care and behavioral health care in all aspects of UM policies and procedures. These include timeframes, classification of determinations, qualifications of decision makers, notification of outcomes, use of clinical criteria, disclosure of criteria to members and providers, authorization requirements, in-network, or out-of-network requirements, and all other regulatory requirements related to utilization management. For Group Care members receiving behavioral health services, medical necessity determinations are based on non-profit professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), World Professional Association for Transgender Health (WPATH) (SOC 8 standards), American Psychiatric Association, and the American Psychological Association.

2. The services below are exempt from prior authorization, based on regulatory requirements:
    a. Emergency Services, whether in or out of Alameda County; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
    b. Urgent care, whether in or out of network
    c. Primary Care Visits
    d. Preventative Services
    e. Immunizations/Vaccines
        i. Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, the Alliance will provide available information on the status of the member's immunizations to the LHD clinic. The Alliance will pay claims from LHD clinics sent with supporting immunization records.
    f. Annual Cognitive Assessment for Medi-Cal members over 65 without Medicare.
    g. Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
    h. Basic perinatal care – a woman can go directly to any network provider for

basic perinatal care

i. Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
j. Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention
k. HIV testing and counseling
l. Minors do not need authorization for:
    i. Sexual or physical abuse
    ii. Suicidal ideations
    iii. Pregnancy care
    iv. Sexual assault
    v. Drug and alcohol abuse treatment
m. Biomarker Testing
    i. Biomarker testing is a covered benefit for the purposes of medically necessary diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment options.
    ii. For all LOB: members with advanced or metastatic stage 3 or 4 cancer, or for cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. The Alliance will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6.
    iii. The Alliance will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.
        a) Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the Medi-Cal website to ensure DHCS lists these codes as billable and payable during any given year. As new coding updates are released by CMS, the Alliance coding list will be updated at least annually. Any updates are configured in the Alliance UM and Claims systems to not require PA for in-network providers for Medi-Cal LOB only.
    iv. For Group Care members, as required in the Cal. Health & Safety Code section §1367.667, the Alliance covers medically necessary biomarker testing, subject to utilization review, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions. Biomarker tests that meet any of the following will be covered:
        a) A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug
        b) A national coverage determination made by the Centers for Medicare and Medicaid Services
        c) A local coverage determination made by a Medicare Administrative Contractor for California

d) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff
e) Standards set by the National Academy of Medicine

3. The below services provided by the Alliance's direct network do not require prior authorization:
    a. Specialty visits (initial and follow-up visits)
    b. Mental Health and Substance Use Disorder outpatient visits
    c. Services/codes that have been reviewed and approved at least annually by the Alliance UM Workgroup~~Committee (UMC)~~ and Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMCC) to remove prior authorization requirements

4. Services Requiring Prior Authorization
    a. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:
        i. Contracted providers are informed in the service agreements by accessing the Provider Manual, the Prior Authorization Grid information located on the Alliance website and are available upon request.
        ii. Non-contracted providers are informed via the Alliance website/Section – Authorization.

5. Services for which authorization is required include, but are not limited to:
    a. Out-of-network providers/ services/ facilities.
    b. Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).
    c. Selected Mental Health Care and Substance Use Disorder treatment (ex. Applied Behavioral Analysis (ABA) for Medi-Cal, and all inpatient, residential treatment, partial hospitalization, intensive outpatient treatments, neuropsychiatric testing, ECT)).
    d. Selected major diagnostic tests.
    e. Home Health Care/ Private Duty Nursing care.
    f. Selected Durable Medical Equipment (DME)
        i. The Alliance's DME Provider California Home Medical Equipment (CHME) follows specific guidance provided by The Alliance which allows CHME to approve some new and replacement DME per agreed upon parameters. These may include equipment such as:
            a) Knee Mobility Scooters (non-motorized)
            b) Cubby Beds
            c) Manual Wheelchairs
            d) Walkers
            e) Incontinence Supplies

f) Respiratory Products such a CPAPs and Nebulizers

g. New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.). See UM-007 New and Experimental Technology Review Process policy.
h. Medications not on the Alliance approved drug list and/or exceeding the Alliance's monthly medication limit.
i. CBAS services.
j. Inpatient admissions (non-emergency).
k. Inpatient hospice care.
l. Inpatient abortions.
m. Skilled nursing facilities admissions.
n. Long-term care (LTC) Custodial Nursing Facility admissions.
o. Intermittent Care Facility for the Developmentally Disabled (ICF/DD) admissions.
p. Subacute Admissions.
q. Major Organ Transplant Services.
r. Out of Network Second opinion.
s. Podiatry services.
t. Acupuncture, greater than four (4) visits per month for Adults. Limits do not apply for children under the age of 21.
u. Chiropractic.
v. Treatment and services related to gender dysphoria.
w. Enhanced Care Management (ECM)

6. Out of Network/Non-Contracted Providers
   a. The Alliance requires services to be provided within the contracted network.
      ~~a.~~i. Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which the Alliance does not have a contracted provider or provider type ~~in~~ in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or Long- Term Care nursing facility capacity.~~:~~
   b. At the time of the initial processing of the authorization request, the Authorization Coordinator (AC) will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue and document the out of network reason for the request.
   c. If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdraw~~ing~~ in the case notes and closes the case.
   d. If the decision is to continue using a non-contracted provider, the AC routes the request to the UM Nurse or BH Reviewer / or Pharmacist to determine if the service is medically necessary and the status of available providers within the network to provide the service.
      i. The UM Nurse / BH Reviewer / Pharmacist reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.

a) If determined services are medically necessary but not available within the Alliance network within the applicable time and distance and timely access standards, the UM Nurse / BH Reviewer / or Pharmacist determines if the non-contracted provider is the most appropriate and approve for initiation of one-time Letter of Agreement (LOA) through Provider Contracting.
    - The Alliance maintains a list of non-contracted providers which may be authorized due to lack of availability within the provider network, as long as medical necessity criteria for the requested service(s) are met.

ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM Nurse / BH Reviewer will call the provider to obtain additional information that will either support or disprove the need for the utilization of an out of network provider.
    a) This call will be documented in the medical record

iii. If the provider continues to request the OON authorization, the UM Nurse / BH Reviewer will refer the case to the Medical Director / Doctoral BH Reviewer / or Pharmacist to review for re-direction into the network.
    a) If determination is to re-direct, the UM Nurse / BH Reviewer / Pharmacist will confirm with the newly identified in-network provider that the services can be provided, and provided within the applicable time and distance and timely access standards.
    b) A referral is made for care coordination to assist the member to navigate the redirected care to a contracted provider.

e. For Out of Network Providers, Medi-Cal covered transportation to the Out of Network provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))

7. Provider Exclusions, Preclusions and Terminations
    a. The Alliance shall not authorize services to providers who are excluded from participation in Medicare, Medi-Cal or other Federal Health Care Programs, except as otherwise required by law
    b. The Alliance shall verify provider's eligibility to participate in federal health care programs through applicable federal and state exclusion and preclusion databases including, but not limited to:
        i. OIG list of Excluded Individuals and Entities
        ii. CMS Preclusion List
        iii. California DHCS exclusion and suspension lists, as applicable
    c. Providers terminated from Alliance participation for quality, fraud, abuse, program, integrity, licensing, sanction or credentialing reasons may not receive new authorizations unless approved through an exception process or required by law or regulation
    d. If a provider is identified as excluded, precluded, sanctioned or terminated after an authorization has been approved, the Alliance shall review the authorization

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and take appropriate action consistent with applicable CMS, DHCS and regulatory requirements.

e. When provider termination, exclusion or preclusion affects a member's access to care, the Alliance shall implement Continuity of Care processes and facilitate transition to an appropriate participating provider.

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~~7.~~8. Enhanced Care Management Authorizations

a. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:
   i. Routine requests not to exceed seven (~~five~~ 7) calendar days.
   ii. Expedited requests not to exceed 72 hours.
b. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:
   i. Provider notification not to exceed 24 hours, (oral or written) after decision.
   ii. Written notification to provider and member not to exceed two (2) working days after decision.
c. The Alliance will authorize ECM for a minimum of six (6) months for each request.
d. Delegated ECM Providers and/ or their subcontractors must follow Alliance authorization requirements, including adjudication standards and referral documentation.
e. ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.
f. The Alliance will identify members who meet the criteria as a member of a population of focus and refer the member to an ECM provider for outreach.
g. The Alliance will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.

~~8.~~9. Authorization of Community Supports (CS) Services

a. Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:
   i. Routine requests not to exceed seven (7) calendar days.
   ii. Expedited requests not to exceed 72 hours.
   iii. Retrospective requests not to exceed 30 calendar days.
b. Notification time frames for authorization request for CS will follow regulatory UM timelines, for example:
   i. Provider notification not to exceed 24 hours, (oral or written) after decision.
   ii. Written notification to provider and member not to exceed two (2) working days after decision.
c. Recuperative Care and Medically Tailored Meals, when offered post an acute care admission, are inherently time-sensitive and subject to expedited authorization timeframes.

~~9.~~10. The Alliance Medical Management Referrals for Autism Services

a. A PCP, a Regional Center, or a family member may refer members to receive

services by contacting the BH Department.

b. All BH related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946 will be routed to the BH Team for referral processing.
c. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or autism.
    i. The BH team will submit any request for non-BH services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.
    ii. UM Staff will process referral requests as defined above
d. UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.

~~10.~~11. Standard Fertility Services

a. Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment). See Policy UM-029 Sensitive Services for further guidance on covered benefits.
b. For Medi-Cal members, the following fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos, are not covered.

~~11.~~12. Indian Health Service Programs

a. The Alliance will ensure qualified Members have timely access to Indian Health Service (IHS) Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).

~~12.~~13. Telehealth

1. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as Prior Authorization (PA) timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the Evidence of Coverage (EOC) specific to that LOB. If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service. If the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a

contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, the Alliance will do the following:

i. Notify the Member of their right to access their medical records pursuant to, and consistent with, Health and Safety Code Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.
ii. Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their Primary Care Physician (PCP), unless the enrollee objects.
iii. Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.
iv. Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

~~13.~~14. Non- Benefit and Unlisted Codes

a. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Physician / Medical Director/ doctoral BH Reviewer / Pharmacist~~y~~ does not have the clinical expertise in treating the requested service to render the UM determination, the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist may consult with a Board Certified Consultant to assist in making the medical necessity determination.
    i. When using a Board-Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will utilize the recommendation in rendering the final UM determination.

b. Non-Benefit Codes
    i. The Alliance may cover a non-covered service if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the non-covered benefit is medically needed.
    ii. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business
    iii. The Alliance UM Nurse Reviewer will use UM criteria (DHCS, LCD, NCD and/ or MCG), patient records to guide the UM decision-making process
    iv. All potential denials of these services will go to the MD for review and final determination

c. Unlisted Codes
    i. The Alliance may cover an unlisted service codes if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the unlisted service code~~s~~ is medically needed.
    ii. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of

business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business

iii. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process

iv. All potential denials of these services will go to the MD for review and final determination

B. UM Review Process

1. Pre-Service Review
   a. Authorization requests are submitted by phone, fax, in writing, or via secure portal.
   b. Upon receipt of the authorization request, the UM Coordinator will review the request for:
      i. Member eligibility
      ii. Completeness of the request
      iii. Presence of medical codes, e.g., ICD-10, CPT, HCPCS
      iv. Presence of medical records.
   c. Once the authorization request review is complete, the UM Coordinator enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.

2. Appropriate Classification of Determination
   a. UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.
   b. Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render them covered then a medical necessity decision is needed.
   c. Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

3. The Alliance service types are processed as:
   a. Prior Authorization
   b. Concurrent
   c. Post-Service/Retrospective Review

4. The Alliance authorization determinations are documented as:
   a. Approved
   b. Modified (Partial approval)
   c. Denied
   d. Delayed
   e. Reduce
   f. Stop
   g. Suspend
   h. Deny
   i. Change
   j. Withdraw

k. Dismiss

5. Auto-authorization is an authorization approval process for contracted providers that utilizes system-generated approvals that do not require a clinical review. The Alliance considers the following factors in determining services to be on auto-authorization:
   a. Regulatory/Contractual guidelines
   b. Member access to services
   c. Utilization patterns:
      i. Volume of authorizations
      ii. Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews
   d. Patient safety
   e. Provider consistency in scope of utilization requests

6. For Authorization requests not determined by system-generated auto-authorization, the UM Coordinator reviews the pre-service authorization request for services that can be approved within the scope of a UM coordinator. The pre-service request workflow:
   a. For requests that can be approved within a UM coordinator's scope, the UM Coordinator approves the request following UM guidelines.
      i. Services that can be approved within the scope of a UM Coordinator does not require licensed clinical review. The Alliance considers the following factors in determining services that can be approved within the scope of a UM Coordinator:
         a) Regulatory/Contractual guidelines
         b) Member access to services
         c) Utilization patterns:
            - Benefit limitations
            - Volume of authorizations
            - Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews

         ~~d)~~ Patient safety

         d)

         e) Provider consistency in scope of utilization requests

      ii. For requests that are beyond the scope of a UM coordinator, or do not meet the parameters that a UM Coordinator can approve, the UM Coordinator routes the request to the UM Nurse/doctoral BH Reviewer~~/or Pharmacy technician~~ for clinical review.

   b. The list of services on auto-authorization and within UM coordinator scope are reviewed and approved at least annually at ~~UMC and~~ QIHE/UMC. UM staff will process requests in accordance with the auto-authorization and coordinator scope guidelines after approval by ~~UMC and~~ QIHE/UMC (see attachment section of the policy).

C. UM Decision Making

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1. The Alliance uses licensed health care professionals to make UM decisions that require clinical judgment. The following staff may approve services:
    a. Qualified health care professionals (licensed physicians), supervise review decisions, including service reduction decisions.
    b. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.
        i. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.
    c. A qualified physician, doctoral Behavioral Healthcare (BH) practitioner, or pharmacist (when applicable) shall review denials, modifications, delays, terminations that are made, whole or in part, based on medical necessity.
    d. UM Reviewers make UM authorization approval decisions based on UM Committee approved auto authorization criteria, coordinator scope and other UM Committee approved UM criteria UM-001, and auto authorization criteria.
        i. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria. ~~and Policy RX-002~~
    e. Qualified Behavioral Health (BH) Reviewer staff make BH authorization approval decisions based on QIHEC and UM Committee approved BH UM criteria.
        i. See UM-012 Care Coordination policy regarding approved BH UM criteria.
    f. A qualified physician, or doctoral behavioral healthcare practitioner as appropriate, shall review any behavioral healthcare denial of care based in whole or in part on medical necessity.
    g. Administrative Denials: Qualified non-clinical staff may make non-medical necessity decisions including administrative denials due to non-eligibility and Retro Authorization submission greater than 90 days.
    h. Retro Authorizations >90 days will still be reviewed for Medical Necessity
    ~~Pharmacy technicians make pharmacy authorization approval decisions based on UM P&T Committee approved Pharmacy Guidelines and Policy RX-002~~
    i. Compensation and performance evaluations of UM staff are not based on denials, reductions or limitations of services.

2. Minimum Clinical Information for Review of UM Requests for Authorization
    a. When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
    b. Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:
        i. Office and hospital records
        ii. A history of the present problem

iii. A clinical exam
iv. Diagnostic testing results
v. Treatment plans and progress notes
vi. Patient psychosocial history
vii. Information on consultations with the treating practitioner
viii. Evaluations from the other health care practitioners and providers
ix. Photographs
x. Operative and pathological reports
xi. Rehabilitation evaluations
xii. A printed copy of criteria related to the request.
xiii. Information regarding benefits for services of procedures
xiv. Information regarding the local delivery system
xv. Patient characteristics and information
xvi. Information from responsible family members
xvii. Minimum Data Set (MDS)
xviii. Preadmissions Screening and Resident Review (PASSR)
xix. Bedbound Certification

3. The Alliance shall process the assessment of appropriateness of medical services on a case-by- case or aggregate basis when UM requests for prior authorization are received before services are provided taking into consideration the following:
    a. Determining and ensuring response appropriate to urgency of request.
    b. Determining and ensuring adequate clinical information is provided to review the request and if not, to work with the requesting provider to obtain for additional specific information needed to review the request.
    c. Ensuring that correct UM criteria are selected for review of request.
    d. Ensuring appropriate review of request by the appropriate level of UM staff and/or Medical Director/ Physician / doctoral BH Practitioner/ Pharmacist.
    e. Ensuring timeframes are met for UM determination of the request and notifications to practitioner and member using the strictest standard.

4. For authorization requests not consistent with the request (i.e., conflicting CPT codes to diagnosis, conflicting HCPCS to documentation, etc.), not meeting UM / BH/ or Pharmacy Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer~~/ Pharmacy Technician~~ forwards the request to the UM Physician/ Medical Director/ doctoral BH/ or Pharmacist Reviewer for review

5. Missing Clinical Information:
    a. Formal requests for missing information can be made either by phone or in writing.
        i. Missing information includes:
            a) Incomplete name, ID number, contact information.
            b) Diagnosis or Service codes
            c) Incomplete Attachments
            d) Required Title XXII forms
    b. When clinical information is missing in the request and the information can

be received within the same day, UM staff (i.e. Coordinators, Nurses, Pharmacists), and if needed the Physician / Medical Directors / doctoral BH Reviewer/ or Pharmacist shall contact the requesting provider by phone to request missing clinical information.

i. Call attempts should be documented in the authorization request case. Up to three (3) attempts will be made:

a) One (1) Fax and two (2) phone calls: The Authorization Coordinator shall make the first call and generate a fax request and make an additional phone call outreach. The UM Nurse / BH Reviewer may also attempt phone outreach, and/or the Medical Director/ Physician / doctoral BH / Pharmacist Reviewer for a Peer-to-Peer request.

6. Request for additional information
   a. Requests for additional information are considered deferrals or delays, and authorizations are pended until reasonably necessary information is received to make a determination.

7. For the Medi-Cal and Group Care lines of business instances where the Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the Alliance shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe or as soon as the Alliance becomes aware that it will not meet the timeframe.
   a. The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.

8. A deferral notice is warranted if the Alliance extends the timeframe up to an additional 14 calendar days because either the beneficiary or provider requests the extension, or the Alliance justifies a need for additional information and how the extension is in the best interests of the beneficiary.

9. For the D-SNP Line of business, the plan may extend the timeframe for a standard or expedites integrated organization determination by up to 14 days in instances where the Alliance cannot make a decision to Approve, Reduce, Stop, Suspend, Deny or Change the request within the required timeframe for a standard or expedited requests because it is not in receipt of information reasonably necessary or requested the Alliance will send out the Coverage Decision Letter template to the provider and beneficiary within the required time frame or as soon as the Alliance becomes aware that it will not meet the timeframe. All requests for extensions must meet the following requirements:
   a. The enrollee or provider requests the extension; or
   b. The applicable integrated plan can show that—
      i. The extension is in the enrollee's interest; and

ii. There is need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.

c. Upon receipt of all information reasonably necessary and requested, UM Nurse/ Physician/ Medical Director / BH Reviewer / or Pharmacist may approve the request for authorization following the strictest timeframe guidance dependent upon line of business.

10. For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer~~/ or Pharmacy technician~~ approves the request and generates the Member and Provider notification using the appropriate template dependent on the Line of business

11. Rescission
    a. No approved authorization shall be rescinded or modified after the provider renders services from UM decisions in good faith for any reason, including, but not limited to, subsequent rescission, cancellation, or modification of the member's contract or when the Alliance did not make an accurate determination of the member's eligibility.
    b. D-SNP Dismissing a request: The applicable integrated plan dismisses a standard or expedited integrated organization determination request, either entirely or as to any stated issue, under any of the following circumstances:
        i. The individual or entity making the request is not permitted to request an integrated organization determination under § 422.629(l).
        ii. The applicable integrated plan determines the party failed to make out a valid request for an integrated organization determination
    c. D-SNP Withdrawal of a request: A request that is made by the enrollee or the enrollees Authorized Representative (AOR) to voluntarily withdrawal their request for a service.

12. An enrollee or the enrollee's representative files a request for an integrated organization determination, but the enrollee dies while the request is pending, and both of the following apply:
    a. The enrollee's surviving spouse or estate has no remaining financial interest in the case.
    b. No other individual or entity with a financial interest in the case wishes to pursue the integrated organization determination.
    c. A party filing the integrated organization determination request submits a timely request for withdrawal of their request for an integrated organization determination with the applicable integrated plan.

13. Notice of dismissal. The applicable integrated plan must mail or otherwise transmit a written notice of the dismissal of the integrated organization determination request to the parties. The notice must state all of the following:
    a. The reason for the dismissal.
    b. The right to request that the applicable integrated plan vacate the dismissal action.
    c. The right to request reconsideration of the dismissal.

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14. Continuation of benefits
    a. Within 10 calendar days of the applicable integrated plan sending the notice of adverse integrated organization determination the plan must continue the enrollees benefits under parts A and V of title XVIII and title XIX if all of the following occur:
        i. The enrollee files the request for an integrated appeal timely in accordance with § 422.633(d);
        ii. The integrated appeal involves the termination, suspension, or reduction of previously authorized services;
        iii. The services were ordered by an authorized provider;
        iv. The period covered by the original authorization has not expired; and
        v. The enrollee timely files for continuation of benefits.

15. Duration of continued or reinstated benefits. If, at the enrollee's request, the applicable integrated plan continues or reinstates the enrollee's benefits, as while the integrated reconsideration is pending, the benefits must be continued until—
    a. The enrollee withdraws the request for an integrated reconsideration;
    b. The applicable integrated plan issues an integrated reconsideration that is unfavorable to the enrollee related to the benefit that has been continued;
    c. For an appeal involving Medicaid benefits—
        i. The enrollee fails to file a request for a State fair hearing and continuation of benefits, within 10 calendar days after the applicable integrated plan sends the notice of the integrated reconsideration;
        ii. The enrollee withdraws the appeal or request for a State fair hearing; or
        i. A State fair hearing office issues a hearing decision adverse to the enrollee.

16. Medical Director / Physician Reviewer Review
    a. The Medical Director / Physician / doctoral BH Reviewer reviews pre-service authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director / Physician Reviewer / doctoral BH reviews the information summary provided by the UM Nurse / BH Reviewer, the clinical information, and the appropriate UM Criteria.
        i. The Medical Director / Physician/ doctoral BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
        ii. To evidence appropriate professional review, each UM case must include one of the following:
            1. The reviewer's written signature or initials
            2. The reviewer's unique electronic signature or identifier on the denial notation
            3. A signed or initialed note from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.

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4. The direct Peer to Peer phone number specific to the MD who made the decision.

b. Once the Medical Director / Physician/ doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse / Coordinator or BH Reviewer for processing:

iii. Approvals: The UM Nurse / Coordinator or BH Reviewer processes the request according to established processes and timeframes.

iv. Delays, Denials, Modifications, or Terminations: The UM Nurse / Coordinator or BH Reviewer processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

D. Peer to Peer Discussions

1. For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with the Alliance decision maker. Providers are notified of this process in the UM determination notifications.
    a. When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with the Alliance UM decision maker.
        i. Oral request includes reading the standard statement for availability of the discussion exactly as identified in the NOA letter/ Integrated Denial Notice.
        ii. "The Alliance has reviewed your request for <<Insert Member Name>>. The Alliance made a determination that this service is not medically necessary. You may also contact the Medical Director / Behavioral Health / Pharmacist reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit."
        v. The Alliance provides easy access for Providers and utilizes direct Peer to Peer telephone number to serve as the entry point of contact.

2. UM Medical Directors will answer the UM calls and obtain the key information to have the UM decision maker return the call:
    a. Member name and ID#
    b. Referral #
    c. Name of the Physician requesting the return call.
    d. Contact number for the requesting Physician.
    e. Best time to reach the requesting Physician.

3. If the Alliance UM / BH/ or Pharmacy decision maker is not available, the Staff will task the request to the UM decision-maker for the day.

4. Every attempt is made to return calls within one business~~on the same~~ day.
    a. Two (2) attempts will be made within a 24-hour period. Each attempt will be documented in the TruCare case.
    b. The Alliance Physician / Medical Director / doctoral BH Reviewer / Pharmacist will document all outreach attempts in TruCare.

5. The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:
    a. In the denial notification, or
    b. By telephone, or
    c. In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.
6. The organization includes the following information in the denial file:
    a. The denial notification, if the treating practitioner was notified in the denial notification.
    b. The time and date of the notification, if the treating practitioner was notified by telephone.
    c. Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

7. The Alliance ensures verbal and written communications to the Member and Providers for UM decisions are provided using the appropriate approved templates and within the UM timeliness standards.

8. Post Service/Retrospective Review Process
    a. The Alliance does not accept post-service or retrospective authorization requests for non- emergent or non-urgent services that would require prior authorization more than 90 days past the date of service. The exception criteria under which a post service / retrospective request greater than 90 days after the date of service which may be considered are:
        i. Member eligibility issues, i.e., retrospective eligibility, unable to validate eligibility at time of service, incorrect eligibility information at time of service.b. In-patient services where the facility is unable to confirm enrollment with the Alliance.

9. If the Alliance receives a request for services >90 days from the Date of Service the request will be reviewed for Medical Necessity and then processed as an administrative denial.
    a. Medical Necessity review will follow the typical UM process
    b. All potential Medical Necessity denials will be sent to the Medical Directors for review.

10. Decision Notification
    a. Once the Medical Director / Physician/ doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse / Coordinator or BH Reviewer for processing:
        i. Approvals: The UM Nurse / Coordinator or BH Reviewer processes the request according to established processes and timeframes.
11. Delays, Denials, Modifications, Terminations, Reduce, Stop, Suspend, Withdraw, Dismiss, Deny or Change

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a. The UM Nurse / Coordinator or BH Reviewer processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

E. Single Plan Model Transition Requirements

1. On January 1, 2024, Alameda County transitioned to a Single Plan Model county, and Medi-Cal recipients transitioned from a previous MCP to Alameda Alliance for Health (Alliance) as their Medi-Cal Managed Care Plan (MCP). Before and during the transition, The Alliance adhered to the requirements of All Plan Letter (APL) 23-018 Managed Care Health Plan Transition Policy Guide (Policy Guide), which establishes the 2024 Managed Care Plan Transition Policy Guide as the DHCS authority, along with the applicable Contract, and any incorporated APLs or guidance documents incorporated into the Policy Guide by reference, regarding the 2024 MCP transition. The continuity of care authorization process for members who transitioned into the Alliance adhered to the requirements of the 2024 Managed Care Plan Transition Policy Guide and APL 22-032 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
2. The Alliance policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.
3. See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

F. Potential Quality Indicator (PQI)

1. If during a UM review process, staff identifies a potential quality of care issue, UM / BH / Pharmacy staff will fill out the PQI Service Request (SR) referral via HealthSuite and forwards to the QI department for review in accordance with QI-104 Potential Quality of Care Issues.

G. Referrals to Care Management

1. If during a UM review process, staff identifies a member may benefit from care management or care coordination, including assisting with redirecting services from an Out of Network Provider to an contracted Provider, EPSDT Care Coordination, Enrollment in an Oncology Program, CCS verification, Behavioral Health, High Risk Transitions of Care Services, or a specific Community Supports/ Complex Care Coordination/ ECM service needs, then the UM staff will complete the Care Management / CCS / BH Referral Form as potential candidate for care management. The form is then forwarded to the Care Management Department / BH for review and assistance in accordance with Care Management / BH Policies.

H. Reporting and Tracking

1. All pre-service requests are entered into the Alliance clinical information system, TruCare, with appropriate documentation reflecting management of the referral including time frames.

2. The HealthCare Analytics department has developed a series of reports which track authorization requests by type, determinations, and timeliness. Reports are produced daily to monitor staff productivity and monthly to report department performance.

b. Monthly report summaries of UM activities are reported to the UM Committee for tracking and trending activities as well as to identify opportunities for process improvements.

c. The Alliance UM / BH / Pharmacy departments provide oversight of delegated entities' compliance with state and federal regulations and Alameda Alliance's delegated UM activities, which includes, but are not limited to, annual, focused, and supplemental audits/file reviews, and other various types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS / ACRONYMS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions for non-eligibility.

B. **Auto Authorizations:** Pre-service authorization requests that do not require clinical review and may be completed by a non-clinical staff member using established QIHE/UMC approved guidelines.

C. **Behavioral Healthcare Practitioner (BHP):** A physician or other health professional who has advanced education and training in the behavioral healthcare field and /or BH/substance abuse facility and is accredited, certified, or recognized by a board of practitioner as having special expertise in that clinical area of practice.

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

E. **Biomarker:** A diagnostic test, single or multigene or an individual biospecimen, such as tissue, blood or other bodily fluids for DNA or RNA alternations, including phenotypic characteristics of a malignancy to identify an individual with a subtype of cancer to guide treatment.

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

G. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.

H. **Doctoral Behavioral Health Reviewer:** A licensed Psychiatrist or Psychologist who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical area of practice.

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

J. **Medically Necessary (Group Care Program for Medical Care):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. [2013 Group Care Program EOC, page 90)

K. **Medically Necessary (Group Care Program for Behavioral Health Services):** "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.
(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. ((iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. (HSC 1372.74(a)(3)(A))

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

i) Consistent with nationally accepted standards of medical practice:

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

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

N. **Member:** Any eligible beneficiary who has enrolled in the Alliance and who has been assigned to or selected a Plan.

O. **National Committee for Quality Assurance (NCQA**): A non-profit organization committed to evaluating and public reporting on the quality of health plans and other health care entities.

P. **Non-Contracted Provider:** A provider of health care services who is not contractually affiliated with the Alliance.

Q. **Post Service or Retrospective:** Utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

R. **Prior Authorization:** A type of Organization Determination that occurs prior to services being rendered.

S. **Provider:** Any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

i) NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA

uses the term Practitioner to refer to the professionals who provide health care services but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

T. **Qualified Health Care Professional:** A primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.

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

V. **UM / BH Reviewer:** A Registered Nurse, Physician Assistant, Psychologist, or Licensed Mental Health clinicians (Licensed Clinical Social Workers, Licensed Marriage and Family Therapists) who is qualified by scope of practice, license, and experience in the use of criteria sets to evaluate clinical factors. Board Certified Behavioral Analysts and licensed qualified autism providers are qualified by scope of practice, license or credential and experience in the use of criteria set to clinically autism services. They apply QIHEC and UM Committee approved criteria to authorize care for members meeting the criteria within their scope of practice.

AFFECTED DEPARTMENTS/PARTIES

All departments

RELATED POLICIES AND PROCEDURES

1. BH-001 Behavioral Health Services
2. BH-002 Behavioral Health Services
3. BH-005 Care Coordination-Behavioral Health
4. BH-006 Care Coordination-Substance Abuse
5. CM-002 Coordination of Care
6. CM-009 ECM Program Infrastructure

~~6.~~7. CRE- D-001 Credentialling and Recredentialling of Individual Practitioners

~~7.~~8. QI-104 Potential Quality of Care Issues

~~8.~~9. QI-133 Inter-Rater Reliability (IRR) Testing for Clinical Decision Making

~~9.~~10. RX-0110~~2 PA Review Process~~ Decision and Notification Requirements

11. RX- 013 Physician/ Facility- Administered Drugs (PAD) Prior Authorization Review Process

~~10.~~12. UM- 036 Continuity of Care

~~11.~~13. UM-054 Policy Notice of Action

~~12.~~14. UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care

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RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Prior Authorization Grid for Medical Benefits on The Alliance website, Provider Section

REVISION APPROVAL HISTORY

11/30/2006, 3/15/2007, 1/1/2008, 9/22/2008, 10/31/2008, 1/16/2009, 4/4/2011, 10/18/2011, 12/30/2011, 4/27/2012, 10/18/2012, 12/12/2012, 05/06/2013, 08/21/2013, 09/24/2013, 10/14/2013,
12/16/2013, 3/13/2014, 5/01/2014, 7/14/2014, 8/6/2014, 8/18/2014, 9/2/2014, 12/1/2014, 10/07/2015, 10/15/2016, 12/15/2016, 12/20/2017, 1/4/2018, 4/12/2018, 3/21/2019, 1/16/2020, 5/20/2021, **3/22/2022, 02/21/2023, 6/20/2023, 12/19/2023, 7/17/2024, 12/18/2024, 12/17/2025, 05/20/2026, 7/27/2026**

Blue = material updates

REFERENCES

Federal

- 42 CFR Part 422
- 42 CFR 422.631
- 42 CFR Part 438
- 42 CFR 438.210
- 42 CFR 438.900(d)
- 42 CFR Part 438 Subpart K
- 42 CFR 455.436
- CMS Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (effective 11/18/2024)
- Addendum to Parts C & D Guidance for Applicable Integrated Plans (effective 1/1/2025)
- CMS Preclusion List Guidance
- OIG LEIE Guidance

DHCS

- DHCS Contract Exhibit A Attachments 5,9, 13
- APL 21*011
- APL 22-010
- APL 23-004
- APL 23-010
- APL 23-023
- APL 23-027

California Statutes and Regulations

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- 28 CCR §1300.51
- Health & Safety Code §§1367.01, 1367.665, 1370.6
- Health & Safety Code §1374.551
- Title 22 CCR §51159
- Welfare & Institutions Code §14197

Accreditation

- NCQA Utilization Management Standards

• 2024 Medi-Cal Managed Care Plan Transition Policy Guide
• 28 CCR, §1300.51 (d)(1-6)
• 42 CFR 422.631 • 42 CFR 438.900(d)
• 42 CFR Subpart K
• APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates
• APL 22-010 Cancer Biomarking Testing
• APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
• APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
• APL 23-018 Managed Care Health Plan Transition Policy Guide
• APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
• APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
• APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care • CMS-10146 Notice of Denial of Medicare Part D Prescription Drug Coverage
• DHCS Contract, Exhibit A, Attachments 5, 9, 13
• DHCS Provider Manual, Family Planning, June 2022, page 1.
• Health & Safety Code, Section 1367.01, 1367.665; 1370.6
• Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).
• D-SNPs: Integration & Unified Appeals & Grievance Requirements | CMS • Medicare parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance eff. 11/18/2024 • Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans Effective January 1, 2025 • NCQA Standards, Utilization Management
• SB 600, Section 1374.551. (a)
• Title 22, Section 51159

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~~WIC Section 14197~~

MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
    b. The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis:
        i. Audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
        iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
3. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. Consistent with HSC Section 1374.721(e)(7), the Alliance ensures interrater reliability pass rate of at least 90% and, if this threshold is not met, immediately provides for the remediation of poor interrater reliability. The Alliance also ensures interrater reliability testing for all new staff before they conduct utilization review without supervision. See QI-133 for additional details about the Inter-Rater Reliability Process.

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POLICY AND PROCEDURE TEMPLATE

Policy Number	UM-058
Policy Name	Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving a Medical Exemption
Department Name	Utilization Management Department
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, D-SNP
Effective Date	5/3/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

Purpose:
This policy establishes guidelines and procedures for ensuring continuity of care for Dual Special Needs Plan (D-SNP) and Medi-Cal plans who have Medical Exempt Requests (MER). This policy ensures compliance with federal and state regulations governing continuity of care while facilitating smooth transitions for members with complex medical conditions.

Scope:
This policy applies to all D-SNP and Medi-Cal members who have been given a MER exemption and are transitioning between care settings, providers, or service delivery systems. It outlines the responsibilities of care managers, providers, and administrative staff in implementing continuity of care provisions.

POLICY STATEMENT

A. This policy describes The Alliance's policy and process to ensure continuity of care for D-SNP and MCP Medi-Cal beneficiaries who transition from fee-for-service (FFS) Medi-Cal into Medi-Cal managed care that are included on the Exemption Transition Data report.

B. The Alliance is required to consider a request for exemption from MCP enrollment that is denied as a request to complete a course of treatment with an existing FFS or nonparticipating health plan provider under H&S Code § 1373.96, and in compliance with the MCP's contract with DHCS and all other DHCS Continuity of Care APLs.

C. Once an MCP is notified that a ~~beneficiary~~ member is on the Exemption Transition Data report, the Alliance must make every effort to ensure that the ~~beneficiary~~ member is allowed to continue to receive ongoing medical/behavioral health care through his or her FFS or nonparticipating health plan provider(s) for the period specified in H&S Code § 1373.96 for a particular illness or condition, including behavioral health conditions. This requirement also applies to instances in which the provider identified on the MER is a specialist who is not included in the network of a subcontracted health plan, independent physician's association, medical group, or other entity to which the ~~beneficiary~~ member is assigned.

PROCEDURE

A. DHCS provides a data file to notify MCPs of beneficiaries who received a MER denial in the past 45 days who have or will transition into an MCP. The Exemption Transition Data report is accessible on the Secure Data Exchange Services (SDES) website for California Health Care Options: http://healthcareoptions.maximus.com/sdes/.
    1. The Exemption Transition Data report is posted to the SDES on a weekly basis using the same schedule and location of the Weekly Plan File (WPF). The file posting schedule is available for download from the SDES website by clicking on the SDES web link above. Authorized MCP representatives who have access to the WPF can access the exemption file.

B. The Alliance Information Technology Department maintains processes to extract the DHCS Exemption Transition Data Report. The IT Department will ensure distribution to the Alliance UM Department within 2 days for processing.
    1. The data file includes beneficiaries who have had a MER denied in the past 45 days. The file contains information for both pending and active beneficiaries. The data file uses the most recent choice/default information on record. For beneficiaries who are pending and not yet active, The Alliance will use the data provided to contact the member ~~beneficiary~~ and initiate the continuity of care process, coordinating Medicare and Medi-Cal benefits for D-SNP members. If there is no exemption denial activity for beneficiaries enrolling, an empty exemption file will not be posted to the site.

C. The Alliance must provide information to beneficiaries about their continuity of care rights as well as to providers (both in and out-of-network) about the requirements.
    1. The Alliance must, at a minimum, include information about continuity of care in provider training and new member orientation materials. For D-SNP members, materials will specify how continuity of care applies to Medicare and Medi-Cal services.

D. The Alliance must treat every exemption listed on the Exemption Transition Data report (see Attachment A for data file format details) as an automatic continuity of care request for the identified memberbeneficiary.

Initiation of CoC based a Medical Exemption Request for

E. The UM team member will review the MERs list. Each member will be assessed for:
    1. Ongoing eligibility with The Alliance, including D-SNP enrollment status
    2. Assigned Provider Network and PCP or assigned Direct Provider.
    3. Availability of Requested Provider in the Alliance Network for Medi-Cal and, for D-SNP members, the Medicare network

F. The Alliance must meet the continuity of care timeframes that are specified in H&S Code § 1373.96. This continuity of care policy is in addition to the extended continuity of care policy for Seniors and Persons with Disabilities established under MMCD 11-019, APL 23-0222-032 on Continuity of Care for Medi-Cal beneficiaries who transition into managed care, and other continuity of care APLs and DPLs.
    1. Timeframes for MER Requests:
        a. Begin processing requests for continuity of care within five (5) working days from their receipt of the request. In this case, receipt of the Exemption Transition Data report constitutes such a request.
        b. Complete their responses to each request within:
            i. 30 calendar days from the date the MCP receives it, or
            ii. 15 calendar days if the memberbeneficiary's medical/behavioral health condition requires more immediate attention, such as upcoming appointments or other pressing care needs.
            iii. If there is a risk of harm to the memberbeneficiary, the request must be completed in three days.
        c. If a memberbeneficiary voluntarily chooses to change MCP (The Alliance) to another MCP, the completion of covered services shall be continued by the new MCP for a period of up to 12 months from the date of enrollment into Medi-Cal managed care.
            i. The Alliance may choose to work with a memberbeneficiary''s out-of-network doctor past the 12-month continuity of care period, but the Alliance is not required to do so.

G. UM team member contacts the Member or Member's Authorized Representative to review the request and explain the process for CoC based on the denial of the MER.
    1. Outreach attempts:
        a. Two documented outreach calls within two (2) business days of identification.
            i. If applicable, on the second failed call attempt a detailed voice message should be left explaining how the memberbeneficiary can contact the MCP.
        b. If there are no responses to the initial 2 phone calls:
            i. Send outreach communication within five (5) business days of identification by the UM Department.

c. If there is no response to written outreach:
    i. Followed by two additional documented telephone calls 5 business days after the mailed communication.
2. When successful contact is made, staff obtain all necessary information to assist in coordination services, i.e., medical records, eligibility segments, claims.

H. A continuity of care request is considered completed when:
1. The member~~beneficiary~~ is informed of his or her right of continued access or if the MCP and the out-of-network FFS provider are unable to agree to a rate;
2. The MCP has documented quality of care issues; or
3. The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.
4. Rendering provider is a Medi-Cal Provider (Medi-Cal LOB only)

I. The Alliance must ensure that all beneficiaries continue to receive medically necessary services and ensure new enrollees are entitled to receive continuity of care with their existing providers, including behavioral health providers, for the completion of those services to the extent authorized by law. The member~~beneficiary~~'s existing provider is identified by the National Provider Identifier on the MER

J. UM team member contacts the requested Provider to ensure the Provider agrees to continue providing services to the member for Medi-Cal and Medicare services (D-SNP members)
1. If the Provider agrees, the UM team member:
    a. Contacts requested provider to ensure they will see member.
    b. Reviews the applicable external databases to assess whether the Provider has any disqualifying quality of care issues.
    c. For D-SNP members the UM team member verifies provider participation in both Medi-Cal and Medicare networks, initiating agreements for Medicare out-of-network providers if needed.
2. If Provider declines to provide ongoing services, the UM Clinical team member will notify the Member and identify an in-network provider to continue the provision of services.

K. Once the Provider is confirmed qualified, the UM team member will:
1. Create UM authorization requests.
2. Clinical review will be completed for the requested services to ensure criteria are met and services are medically necessary if applicable.
3. Criteria (Health and Safety Code 1373.96):
    a. **An acute condition:** An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
    b. **A serious chronic condition:** A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires

ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

c. **A pregnancy:** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy and immediately after the delivery for up to 12 months.
d. **A terminal illness:** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.
e. **The care of a newborn child between birth and age 36 months**: Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
f. **Performance of a surgery or other procedure** that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

4. The UM team member documents determination in authorization requests.
    a. Approvals – UM team member contacts Member to inform them of the approval determination and next step. The UM team member:
        i. Notifies Provider Relations (PR) to begin Letter of Agreement process.
        ii. The UM Team Member completes authorization request, generates, and sends Approval Notification to Member, Provider, assigned PCP and assigned Provider Group.
    b. For potential denials based on request not meeting service criteria or Provider refusing to see Member or accept rates, the UM team member routes case to the UM Medical Director/ doctoral level Behavioral Health Practitioner with all the information documented in TruCare authorization requests.
5. The Medical Director/doctoral level Behavioral Health Practitioner will review all available information and make final determination, considering Medi-Cal and Medicare CoC rules for D-SNP members.
    a. If determination is to approve, the UM Medical Director documents review in TruCare authorization notes section and routes to UM team

member to complete communications. Documentation should include the type of CoC applicable to case and why services are met.

b. If determination is to deny, the Medical Director/ doctoral level Behavioral Health Practitioner documents review in TruCare authorization notes section and routes to UM team member to complete Member communications. Documentation should include:
   i. Type of CoC applicable, why services are not met and the applicable denial reason;
   ii. Confirmation that the services can be provided in-network and communication with PCP to obtain the necessary services and authorizations.

6. Development of Plan of Care
   a. The Alliance UM Department UM staff will coordinate with OON Provider to obtain a copy of the plan of care during the OON service. The Plan of Care will be shared with the assigned PCP and/or Provider Group to ensure all services necessary to manage the identified treatment plan are in place or arranged.
   b. For coordination of care and care transition efforts required under H&S Code § 1373.96, DHCS strongly encourages MCPs to allow non-contracted providers to continue a member~~beneficiary~~'s treatment plan for other, non-contracted services, such as laboratory testing and durable medical equipment and maintenance.

L. The Member is notified of the ongoing assignment to the Primary Care Provider for all preventive services and non-CoC related services.

M. Transition to In-network
   1. For approved CoC, Members will be informed of the approved services, frequency, and duration for services with the OON provider.
   2. The Alliance will monitor open existing authorizations with OON providers by the identified UM report.
   3. One month prior to the expiration of the CoC authorization, the UM Department sends a "CoC ending" notice to the member and OON provider, and notifies case management to coordinate with the Provider and the Member to begin transitioning services to the in-network provider.

N. Annual Training
   1. Staff receives annual training updates on process for CoC including Medicare Regulations for D-SNP Members.

O. Delegation
   1. MCPs must oversee and remain accountable for the requirements if they subcontract with another health plan, independent physician's association, medical group, or other entity. In addition, MCPs must monitor subcontractors to ensure compliance with this policy. If the member~~beneficiary~~'s FFS or nonparticipating health plan provider is not an in-network provider, the MCP must contact the provider and make a good faith effort to enter into a contract,

letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the memberbeneficiary.

2. For services that are the responsibility of the delegate, the UM team member will facilitate and coordinate with the assigned delegate CoC contact. The UM team member documents in the TruCare authorization request the name and phone number of the delegate contact. The authorization request determination is cancelled as responsibility of PPG and case is closed. Delegates are required to process the CoC request as defined by policy or regulation.

DEFINITIONS / ACRONYMS

1. **Medical Exemption Request (MER)** means a request for temporary exemption from enrollment into a managed care plan (MCP) only until the member's medical condition has stabilized to a level that would enable the member to transfer to an MCP provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to members transitioning from FFS to Managed care plan. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above.

2. **Authorized Representative:** means a person other than the plan member who is authorized to receive confidential information related to the member, and who may speak on the member's behalf.

3. **California State Plan**: In response to the CMS guidance and in accordance with Title 42 Code of Federal Regulations Section 440.130(c), the Department of Health Care Services (DHCS) issued interim guidance on September 15, 2014 in APL 14-011 to include BHT services as a covered Medi-Cal benefit for beneficiaries under 21 years of age when medically necessary, based upon recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of ASD to the extent required by the federal government.2 BHT services, such as Applied Behavior Analysis (ABA) and other evidence-based interventions, professional services, and treatment programs, prevent or minimize the adverse effects of ASD, and promote, to the maximum extent practicable, the functioning of a memberbeneficiary with ASD.

4. **Continuity of Care (COC):** means a process for ensuring that care is delivered seamlessly across a multitude of delivery sites and transition in care throughout the course of the disease.

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

6. **Fee-for-Service (FFS):** means a method of payment based upon per unit or per procedure billing for services rendered to an eligible memberbeneficiary.

7. **Managed Care Provider (MCP):** means a participating provider or a contracted provider in a Medi-Cal Managed Care Health Plan.

8. **Medically Necessary or Medical Necessity:** Those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical practitioner, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain, that are: consistent with nationally accepted standards of medical practice:
    a. "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.
    b. For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
    c. For purposes of covered services for Medi-Cal members, the term "medically necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and
    d. When determining the medical necessity of Covered Services for a Medi-Cal member under the age of 21, "medical necessity" is expanded to include the requirements applicable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT Supplemental Services as defined in Title 22, 51340 and 51340.1.

9. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), Alliance will apply the definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards as follows:
    a. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body enrollee, or otherwise medically necessary under 42 CFR §1395y;
    b. For Medi-Cal services: reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under Title 22 California Code of Regulations (CCR) Section 51303.

10. **Members:** Any eligible memberbeneficiary who is enrolled in any of Alliance's product lines of business.

11. **Out of Network (OON):** means a non-participating provider or a non-contracted provider in a Medi-Cal Managed Care Health Plan.

12. **Primary Care Provider (PCP):** means a primary care physician or clinic responsible for coordinating, supervising, and providing primary health care services to a member,

including but not limited to initiating specialty care referrals and maintaining continuity of care.

13. **Provider:** means primary care physicians, specialists, ancillary providers, clinics, and hospitals.

14. **Quality of Care Issue (DHCS definition)** means The Alliance can document its concerns with the with the Provider's quality of care to the extent that the Provider would not be eligible to provide services to any other Alliance members.

15. **Risk of Harm** is defined as an imminent and serious threat to the health of the member.

16. **Seniors and People with Disabilities (SPD):** means person(s) 65 years or older and/or individual(s) meeting one of the following criteria: he or she has a physical or mental impairment that substantially limits one or more of his/her major life activities; he or she has a record of such an impairment; he or she is regarded as having such an impairment.

17. **Treatment Authorization Request (TAR):** means a referral or request for services. Services may be initial or ongoing.

18. **Dual Special Needs Plan (D-SNP):** A Medicare Advantage special needs plan that enrolls individuals who are entitled to both Medicare (Title XVIII) and state Medicaid plan (Title XIX) as defined in 42 CFR 4222.2

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Member Services
Provider Relations
Compliance

RELATED POLICIES AND PROCEDURES

- UM-036, "Cont. Covered Services for Members with Terminated Providers"
- BH-001, Behavioral Health Services, Medi-Cal
- BH-008, Behavioral Health Services, Group Care
- BH-, Behavioral Health Services, D-SNP

REVISION HISTORY

5/3/2018, 4/16/2019, 3/18/2021, 3/22/2022, 6/20/2023, 7/17/2024, 05/20/2025, 7/27/2026

REFERENCES

1. 42 CFR 422.2. 101, 112, 208, 438, 514
2. All Plan Letter 11-019 Extended Continuity of Care for Seniors and Persons with Disability
3. All Plan Letter 17-007 Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption
4. All Plan Letter 18-006 Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder Health and Safety (H&S) Code §1373.96
5. All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data
6. All Plan Letter 23-0222-032 Continuity of Care for Medi-Cal Beneficiaries Who Transition Into Medi-Cal Managed Care
7. Welfare and Institutions Code §14185 (b)

MONITORING

A. Delegated Medical Groups
   1. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
   2. The Alliance reviews reports from delegated groups for continuity of care.

B. Internal Monitoring
   1. The Utilization Management Department, on a routine basis, reviews:
      a. Logs/Reports of the various continuity of care requests. Audits are performed on selected files to ensure compliance with the regulatory requirements.
      b. Complaints and grievances for continuity of care are reviewed to identify problems and trends that will direct the development of corrective actions plans to improve performance.
   2. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.

C. Monthly Reports
   1. Department of Health Care Services (DHCS)
   2. The Alliance submits monthly reports for Continuity of Care following the submission process and format outlined in the DHCS All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data.

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POLICY AND PROCEDURE

Policy Number	UM-070
Policy Name	UM ~~UM System Controls~~Information Integrity
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Line(s) of Business	MCAL, IHSS, D-SNP
Effective Date	07/15/2021
Administrative Oversight Committee Approval Date	~~12/29/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") has advanced UM Information Integrity~~system controls~~ to protect data from being altered outside of prescribed protocols.

UM Information Integrity is defined as maintaining and safeguarding information used in the Utilization Management (UM) decision-making and denial notification processes to ensure accuracy, completeness, readability, and protection against unauthorized or inappropriate modification. ~~Scope of UM information, UM denial information integrity is defines as maintaining and safeguarding information used in UM denial decision process against inappropriate documentation updates.~~

Alameda Alliance for Health's information integrity policy protects the following type of information:

- UM Requests from members or their authorized representatives
- UM request receipt date
- Appropriate practitioner review
- Use of board-certified consultants
- Clinical information collected and reviewed
- UM decision
- UM decision notification date
- UM denial notice

The Alliance has advanced information integrity~~system controls~~ capabilities specific to UM denial notification dates that:

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~~1.~~ 1. Defines the date of receipt consistent with NCQA requirements

~~a.~~a. See UM-051 Timeliness of UM Decision Making and Notifications for detail on required timelines for determination and notification of decisions.

~~a.~~ 2. The date of receipt in the UM denial system is defined as the date when the authorization is requested via Provider Portal, ADT feed, fax, or mail at the Alliance, even if it is not received by the Utilization Management Department~~.~~

~~i.~~a. Via Provider Portal. The time and date that the request was submitted and accepted through the Provider Portal.
~~ii.~~b. Via ADT hospital data feed. The time and date the request was received via data feed by the Alliance.
~~iii.~~c. Via Fax. The time and date that the fax was received by the Alliance.
d. Via Mail. The time and date that the request was date stamped by the Facilities Department.
~~iv.~~

~~b.~~3. The Alliance counts the time from the date when the Alliance receives the request, whether or not it is during business hours.

a.
~~3.~~ Defines the date of written notification consistent with NCQA requirements
~~a.~~ b. AAH adheres to the NCQA UM timeliness requirements for written notifications.
~~i.~~ c. The date of written notification is when the Alliance gives written notification of decision to members and providers either via fax, dated with fax confirmation or mailed with a dated postmark. See UM-051 Timeliness of UM Decision Making and Notifications for detail on required timelines for determination and notification of decisions

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PROCEDURE

1. Recording dates in system:
   a. Date of Receipt. Receipt date is documented in the Request date field upon receipt of a request for authorization by the UM staff, who enters the request into system of record, TruCare, (TC). The TC system automatically records the date and time of the entry. If the request date is different than the entry date the staff manually enter the correct receipt date.
   b. Fax ADT feed and Portal System Requests automatically generate an entry date and request date
   c. Date of Written Notification:
      i. Once the decision is made, the staff enters it into TruCare. The TC system automatically records the date and time of the determination and the Notification. Notification dates are system-generates, time stamped, maintained in the Alliance System and cannot be altered after the notification letter is produced. ~~fields are locked and cannot be changed once a notification letter is generated.~~

ii. If a change in the content of the Notification letter is needed after the dated Notification letter is generated, the specific authorization line request is voided, and a note entered about the reason for the change. The case is redetermined and a new Notification letter is generated. The original authorization record remains part of the permanent audit trail and cannot be deleted.

2. Staff roles
   a. The following staff are responsible for documenting completion of UM activities:
      i. UM Nurses, UM Coordinators, Behavioral Health Nurses, Long-Term Care Nurses, Long-Term Care Coordinators, Community Supports Nurses and Community Supports Coordinators.
      ii. UM Supervisors, UM Managers
   b. The following staff are authorized to modify (edit, update, [delete]) UM information:
      i. UM Supervisors
      ii. UM Managers
      iii. UM/ LTSS Directors
      iv. Executive~~Senior~~ Director Health Care Services
   c. The following staff are responsible for oversight of UM information integrity functions, including auditing functions:
      i. UM Director (or designee)
      ii. UM Manager (or designee)

3. Process for documenting updates to UM Information:
   a. Circumstances when UM information may be updated:
      i. UM Denial System Error. When there is a technical error in the system confirmed by the Information Technology Department. Example: Date in system incorrect.
      ii. Administration Error. When any UM staff member entered the incorrect request/receipt date or time into the system. Example: When any UM staff entered incorrect UM information into the system.
   b. Request dates/Receipt date:
      i. Prior to a Determination, request/ receipt dates may only be corrected by authorized supervisory staff identified in Section 2(b) when documentation supports the correction. ~~any staff member cannot change request date (receipt date).~~ Once a denial determination is made, the request/receipt date cannot be changed.
   c. If a system failure occurs that affects the recording of the date and time, the Sr. Director of Health Care Services, Director of Utilization Management/Long-Term Services or Supports, or the Managers of Inpatient/Outpatient/Long-Term Care Utilization Management will work with IT to develop an ad hoc report to determine the scope of the error and remediation actions to be taken. Notification dates are automatically generated by the system when the notification date is entered and cannot be changed.
   d. After the Notification is dated in the system, if a change is needed, the staff member notes in the system when an authorization is voided and the reason for the void.

e. Voiding an authorization is allowed for an administrative error, such as wrong member or other content error. Voiding authorizations to modify receipt dates or notification dates is not allowed.

~~d.~~ Falsifying UM dates are not permitted. ~~,~~ A~~a~~d hoc reports (Weekly, Bi-Weekly and Monthly) are used to identify, monitor and trend documentation errors, unauthorized modifications, and system integrity issues. Findings are reviewed by UM leadership and corrective actions are implemented when necessary. ~~will determine the score of the error. (e.g., receipt date, UM decision date, notification date).~~

4.

~~4.~~5. Tracking modified UM information:

a. The TC system tracks all changes and modifications to UM information, (including voided authorizations). This tracking protects the information from being fraudulently altered, the TC system documentation includes who made the change, what was changed (request date or voided authorization) and when the change was made. This is a system generated staff ID with the date and time of entries that cannot be changed. A note must be completed by the person making the change to explain why the date was modified.

b. If a system failure occurred that affected the recording of the date and time, the Executive Director~~Sr. Manager~~ of Health Care Services, Director Utilization Management/ LTSS or the Manager of Inpatient/Sr. Manager of Outpatient Utilization Management will work with IT to develop an ad hoc report to determine the scope of the error and remediation actions to be taken.

~~b.~~c. Audit trail records are retained in accordance with Alliance record retention requirements and are available for compliance, regulatory and accreditation review.

~~5.~~6. Inappropriate documentation and updates:

a. The following documentation and updates to UM information are inappropriate:

i. Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
ii. Creating documents without performing the required activities
iii. Fraudulently altering existing documents (e.g., clinical information, board ~~-~~certified consultant review denial notices).
iv. Attributing review to someone who did not perform the activity (e.g., appropriate practitioner review).
v. Updates to information by unauthorized individuals

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7. Tracking Dismissals and Withdrawals for D-SNP Determination Requests

~~6.~~a. Dismissals and withdrawals must be documented in a manner that preserves information integrity and maintains an auditable record of actions taken.

~~a.~~b. Withdrawal

i. A request for initial determination can be withdrawn at any time before a decision is issued
ii. The request for a withdrawal must come from the party who requests the initial determination

~~b.~~c. Dismissal

i. Plans must dismiss a request for an initial determination under any of the following circumstances:

- The individual or entity making the request is not permitted to request an initial determination under the applicable regulation.
- The plan determines that the individual or entity making the request failed to make a valid request for an initial determination that substantially complies with 42 CFR §§ 422.568(a) or 423.568(a). *A valid request, as contemplated in §§ 422.568(a) and 423.568(a), includes sufficient information to identify the enrollee to allow the plan to adjudicate the request (or, at a minimum, make contact with the enrollee to clarify the request), including a full name or member ID number or at least one means of contact (e.g., address, telephone number, email).* In addition, under Part D, an enrollee may not request a tiering exception for an approved non-formulary prescription drug. See 42 CFR § 423.578(c)(4)(iii). In this circumstance, a plan would dismiss the request and issue a dismissal notice in accordance with the notice requirements at § 40.15.1.
- The enrollee dies while the request is pending and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the initial determination. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.
- The individual or entity who requested the review submits a timely verbal or written request for withdrawal of their request for an initial determination with the plan.

~~7.~~8. All UM system data is secured in accordance with AAH IT policy and procedures.

a. Password-protecting electronic systems is outlined in IT-003 Password Management Policy, the policy includes requirements for:
   i. Using strong passwords
   ii. Avoiding writing down passwords
   iii. User IDs and passwords unique to each user
   iv. Changing passwords periodically

b. Access to the electronic systems is outlined in IT-010 Access Authorization Policy, the policy includes requirements for:
   i. Limiting physical access to the system; therefore, preventing unauthorized access and changes to system data.

c. Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security is outlined in IT-009 Access Termination Policy. When staff leave the organization or move to a new role and no longer need access to the TruCare UM system, Human Resources notifies IT to remove access.

DEFINITIONS / ACRONYMS

1. **TruCare**: The Alliance's UM Information System where authorization requests are processed.

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2. **Advanced Information Integrity~~System Control~~ Capabilities**: The Information System has the capability to both automatically record dates and to prevent changes that do not meet the organization's policies and procedures.

~~2.~~3. **Information Integrity**: The protection of UM data from unauthorized creation, modification, deletion, or alteration while maintaining a complete audit trail.

AFFECTED DEPARTMENTS/PARTIES

- Utilization Management Department

RELATED POLICIES AND PROCEDURES

- CMP-101 Corrective Action Plan
- CMP-400 Delegation Oversight
- IT-003 Password Management Policy
- IT-009 Access Termination Policy
- IT-010 Access Authorization Policy
- UM-001 Utilization Management

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

7/15/2021, 11/23/2021, 6/28/2022, 10/19/2023, 12/18/2024, 12/25/2025, 7/28/2026

REFERENCES

- NCQA UM 1~~2~~: UM ~~System Controls~~Information Integrity, Element A: Protecting the Integrity of UM Denial Information
- NCQA Policies and Procedures (Section 5) Reporting Hotline for Fraud and Misconduct; Notifying NCQA of Reportable Events
- ~~42 CFR 422.107~~
- 42 CFR §§ 422.568(a)
- 423.568(a)

MONITORING

The Alliance conducts audits to identify and assess and ensure that this policy and procedure is followed.

1. External Delegates
   a. The Compliance Department has oversight of the Annual Delegation Review of UM delegates as outlined in CMP-400 Delegation Oversight.

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b. The Executive~~Sr.~~ Director of Health Care Services or the Manager of Inpatient/Outpatient Utilization Management reviews 30 UM denial files on an annual basis.
c. The Compliance Department has oversight of the Corrective Action Plan as outlined in CMP-101 Corrective Action Plan, as needed.

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2. Internal UM Denial Systems
   a. UM Denial Audit Review
      ~~i.~~1. Internal audits are conducted quarterly to support operational monitoring.
      ~~ii.~~2. An annual audit is completed and reported at the UM Committee, and then to the QIHE/UMC
      ~~iii.~~3. Audit Process: The UM Director, Manager or designee is responsible for oversight of the UM Information Integrity~~System Controls~~ Audits. The UM Information Integrity~~System Control~~ Audit is performed by the UM Director, Manager, or designee.
      ~~1.~~4. Quarterly the UM Director, Manager, or Supervisor reviews the report from the TC Analytics Department of all receipt date modifications. The report is generated 10 days after the end of the quarter.
      ~~2.~~5. The UM Director, Manager, or Supervisor makes a random selection of 5% or 50 charts, whichever is fewer, for review against the Information Integrity ~~system control~~ requirements.
      ~~3.~~6. The cases are reviewed for documentation of a receipt date change, with date of change, change made by the appropriate staff and for an acceptable reason.
      ~~4.~~7. If any date modifications does not meet the acceptable process as outlines in the Alliance policy, a qualitative analysis is conducted, and action will be taken to correct the issue.
      ~~5.~~8. The results of the audit and any and any identified inappropriate documentation and updates are reported to the UM Director. If any fraud or misconduct is identified (identification of systemic issues (e.g., falsifying UM request receipt dates) affecting 5% or more of UM files), the UM Director will make a report to NCQA's Reporting Hotline: English-speaking USA and Canada 844-440-0077 Spanish-speaking North America 800-216-1288 (from Mexico, user must dial 001-800-216-1288). Website: https://www.lighthouse-services.com/NCQA
      ~~6.~~9. Consequence for Inappropriate documentation and updates may include staff training conducted on an ad-hoc basis by the Manager of Inpatient/ Sr. Manager Outpatient Utilization Management. Training consists of changed to any applicable state regulation, and implementation of new or updated policy and procedure. Training is documented and require evidence of the participants involved. Individuals found making inappropriate documentation and updates may be subject to disciplinary actions up to and including termination.
      ~~7.~~10. AAH Continues to monitor using a follow up audit for three to six months after the annual audit to ensure information integrity.

~~8.~~11. If AAH identifies findings less than three quarters before the NCQA survey submission date. AAH submits all monitoring information it has available so much

~~iv.~~ii. The Manager of UM is responsible for taking actions and ensuring the effectiveness of these actions are monitored in the quarterly reports.

POLICY AND PROCEDURE

Policy Number	UM-D-001
Policy Name	Prior Authorization/Concurrent Review/Organization Determination Audit Process Policy (RGR)
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	D-SNP
Effective Date	9/17/2025
Administrative Oversight Committee Approval Date	~~7/15/2026~~TBD

POLICY STATEMENT

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

~~This policy applies to all PA, CR, OD processes conducted by the Alliance including internal staff, contracted providers, and delegated entities involved in utilization management.~~This policy applies to all PA ,CCR, and OD activities conducted by the Alliance, including activities performed by Alliance staff, contracted providers, delegated entities, and subcontractors responsible for utilization management functions.

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PROCEDURE

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

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

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

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

DEFINITIONS

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

AFFECTED DEPARTMENTS/PARTIES

Behavioral Health
Utilization Review

RELATED POLICIES AND PROCEDURES

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

REVISION APPROVAL HISTORY

New Policy: 9/17/2025

Updates Approved: **7/15/2026, 7/26/26**

Blue: Material Updates

REFERENCES

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

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	UM-D-003
Policy Name	Readmission Review Policy
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	D-SNP
Effective Date	9/17/2025
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Wellness (the Alliance) is committed to reviewing all readmissions within 30 days. The Readmission Review Policy establishes a process to evaluate readmissions for members, ensure medical necessity, optimize resource utilization, and reduce potentially preventable readmissions (PPRs). This policy complies with Centers for Medicare & Medicaid Services (CMS) regulations and California Department of Health Care Services (DHCS) requirements under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

This policy applies to all Alameda Alliance for Wellness D-SNP members readmitted to an acute care hospital or skilled facility within 30 days of a prior discharge. It governs UM staff, contracted providers, and network facilities.

PROCEDURE

A. Readmission Notification
   1. Providers notify The Alliance UM and CM teams within 24 hours via Admission, Discharge and Transfer (ADT) feed, portal, fax, telephone (admission date, diagnosis, prior discharge date, facility, reason for admission)
   2. Verify member eligibility and document readmission in the Clinical information system.

B. Initial Medical Necessity Assessment
   1. Within 48 hours, the UM team reviews clinical documentation (e.g., admission records, prior discharge summary, HRA) to confirm medical necessity of the readmission.
   2. The team applies CMS Hospital-Wide Readmission Measure and DHCS PPR criteria to classify the readmission as potentially preventable or non-preventable.

3. Utilization patterns, including frequency of covered services (e.g., SNF care, outpatient visits) are evaluated via claims data/previous authorizations.
4. Findings, including SDOH factors (e.g., lack of transportation), are documented in the Clinical Information System.

C. Root Cause Analysis for PPR Determination
1. Upon notification of readmission, and within 7 days of readmission or prior to date of discharge (whichever occurs sooner), the UM and CM teams conduct a detailed review to identify factors that contributed to the readmission.
   a. Clinical appropriateness of the prior discharge (e.g., incomplete medication reconciliation)
   b. Adherence to prescribed treatment plans, verified through claims and provider records.
   c. SDOH impacts (e.g., transportation, housing instability), cross referenced with HRA data.
2. The team consults the discharging facility and primary care provider for additional clinical context.
3. PPR status and root causes are documented in the Clinical Information System

D. UM/CM Recommendations
1. Within 7 days, the UM/CM team issues recommendations to providers to optimize utilization.
2. Recommendations include:
   a. Increased utilization of Medi-Cal services (e.g., non-emergency medical transportation, home health).
   b. SDOH interventions (e.g., referral to housing navigation programs), aligned with CalAIM.
3. Recommendations are distributed to the discharging facility and primary care provider via secure communication.

E. Monitoring and Evaluation of UM interventions
1. Readmission patterns are analyzed 30 days post-readmission to evaluate the effectiveness of UM interventions.
2. The UM team tracks provider adherence to recommendations using claims data and provider-submitted reports.
3. Outcomes are documented in the Clinical Information System, identifying trends in PPR reduction and persistent utilization issues.

F. Referral to Case Management
1. UM Nurse to ensure member is referred to Case Management for care coordination in order to prevent readmission.
   a. Case Management referrals are sent automatically to Case Management based on the ADT feed process
   ~~1.~~b. In additional to the automatic referrals, IP nurses are evaluating for significant changes in condition, or high risk diagnosis and will submit manual referrals to case management as appropriate.

DEFINITIONS

- Readmission: An unplanned admission to a hospital within 30 days of discharge from a prior acute care hospitalization.
- Potentially Preventable Readmission: A readmission that could have been avoided through appropriate clinical interventions, such as improved discharge planning or follow-up care.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy: 9/17/2025
Updates: 7/28/2026

REFERENCES

- CMS Medicare Managed Care Manual, Chapter 4.
- 42 CFR Part 422 (Medicare Advantage Regulations).
- DHCS D-SNP Contract, Exhibit A.
- MCG Guidelines.
- CMS D-SNP Model of Care Requirements (42 CFR §422.101(f)).
- CMS Hospital-Wide Readmission Measure.

MONITORING

- Track utilization outcomes via claims data and Clinical Information System.
- Analyze readmission trends quarterly to address inefficiencies (e.g., overutilization).
- Implement corrective actions (e.g., provider training on medical necessity).
- Submit data to CMS and DHCS.
- Provider non-compliance may result in corrective action or contract termination.
- Share reports with UMC quarterly for oversight.

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POLICY AND PROCEDURE

Policy Number	UM-D-007
Policy Name	New and/or Experimental Technology Review Process
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	D-SNP
Effective Date	9/17/2025
Administrative Oversight Committee Approval Date	~~9/17/2025~~TBD

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) has an established mechanism for reviewing new and/or experimental technology as well as a new application of existing technology. The intent of the evaluation of new developments in technology and new applications of existing technology is to ensure that Alliance members have equitable access to safe and effective care.

The Alliance reviews new technology and new ~~application~~applications of existing technology for inclusion in plan benefits. This review encompasses the following:

- Medical and/ or Surgical procedures
- Behavioral healthcare procedures
- Clinical Trials
- Pharmaceuticals
- Devices

The Alliance's new technology evaluation process will include:

- The process and decision variables the plan uses to make determinations, including review of:
    - Member access to services
    - Utilization patterns
    - Patient safety
    - Provider consistency in scope of utilization requests

- A review of information from appropriate government regulatory bodies, including the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), and the Centers for Medicare and Medicaid Services (CMS).
- A review of information from published scientific evidence.
- Obtaining input from relevant specialists and professionals with expertise in the technology.
- The Alliance's coverage decisions will be based on an assessment of new technology and new applications of existing technology, or on a review of special cases.

PROCEDURE

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A. New and Experimental Technology Criteria Implementation Process

1. Review and assessment of new and/or experimental technology is the sole responsibility of Alameda Alliance for Health in concert with State and Federal regulatory requirements and is not delegated to any health care partner or Delegated Medical Group. The process is designed to address recognizing and evaluating advances in medical, surgical, pharmaceutical, and behavioral health care technologies and includes review of the following:
    a. Medical and Surgical procedures, including transplants
    b. Drugs and pharmaceuticals
    c. Behavioral healthcare procedures
    d. Diagnostic and screening tests
    e. Alternative therapies
    f. Medical devices/equipment
    g. Clinical interventions
    h. Clinical Trials

B. Annual Review

1. Formal medical policy review (including medical, behavioral health and pharmacy) is conducted once a year using a two-step process requiring input from the Alliance Health Quality Improvement Health Equity/ Utilization Management Committee (QIHE/UMC).
    a. The first step in the process is to propose the technologies and changes to technologies to be evaluated
    b. The second step is the actual revision of existing, or creation of new, policies using special case reviews are conducted throughout the year which are then They are then approved by the CMO in accordance with review processes and timelines. The information from both processes is used for benefit determinations and coverage decisions.

C. UM Medical Director providing a proposed list of services for consideration at QIHE/UMC to CMO

1. The UM Medical Director will provide the proposed list of services and technologies to the CMO along with a summary and rationale for why the services should be evaluated.

2. The CMO, and the appropriate Medical Directors will identify benefit topics for which coverage policy development is indicated, i.e. sufficient benefit guidance/criteria for new or experimental technology are lacking.

3. The Alliance uses appropriate industry resources to develop unbiased, evidenced-based assessments of the safety and efficacy of new, emerging, and controversial health technologies and evaluation of the impact of these technologies on healthcare quality, utilization, and cost.

4. The Alliance Pharmacy Department will evaluate all new drugs that come onto the market within 6 months.

D. Process for the QIHE/UMC preparation and proposal

1. In preparing for the policy review, the UM Medical Director will coordinate the collection of necessary information about new and/or experimental technology and new uses of existing technology for review by the CMO, who will then propose to the QIHEC the subject areas to be evaluated:
2. The CMO will present the list to the QIHE/UMC for discussion and approval.

3. The CMO will obtain input from the ~~(~~QIHE/UMC~~)~~ and the Pharmacy and Therapeutics Committee (P&T) for specific subjects and recommendations for review of new and/or experimental technology that should be considered for benefit coverage policy development.

E. Process following QIHEC Approval

1. Once the QIHE/UMC approves the list of subject areas, the Alliance UM Medical Director, Pharmacy Director, or Behavioral Health (BH) Director will develop coverage policies that support decisions about use of new technology and new application of existing technology.
    a. The UM Medical Director, with Medical Management Department staff (including pharmacy and behavioral health staff where relevant), will review all relevant research on the service, technology or procedure, from available resources.

F. Development of specific coverage policies

1. The UM Medical Director, Pharmacy Director and BH Director will develop an initial

assessment for specific each new or experimental technology topic consisting of an evaluation of scientific evidence to form conclusions about the benefits/risks of a particular device, therapy, procedure, diagnostic test, or preventive strategy in relation to its potential clinical use for a defined group of individuals.

G. CMO Review and approval of draft coverage policies and final approval at QIHE/UMC

1. The CMO reviews the draft coverage policies that are developed and presents the review of new and/or experimental technology research findings to the QIHE/UMC (and P&T for applicable pharmaceutical technology) for discussion and decision.
2. The UM Medical Directors will draft the Coverage Policy Statement for CMO review and approval.

H. Policy Distribution to Providers

1. Following CMO approval, each Coverage Policy Statement will be made available to providers through:
    a. Announcement of policy publication and availability in the next scheduled Provider Bulletin
    b. Contacting the UM Department at to request policy copies
    c. Posting on Alliance website Provider Portal (when feature is available).

I. Clinical Trials Coverage

1. For D-SNP coverage of Clinical Trials, the Alliance is responsible for verifying the proposed Clinical Trial falls into one of two categories:
    a. Trials that are automatically covered are trials that meet one of the following criteria:
        i. Funded by NIH, CDC, AHRQ, CMS, DOD, or VA;
        ii. Supported by groups funded by those agencies;
        iii. Conducted under FDA-reviewed INDs;
        iv. IND-exempt drug trials (temporarily covered until self-certification is implemented).
    b. Other trials may be considered but they must meet all of the following:
        i. Study an item/service within a Medicare benefit category;
        ii. Have therapeutic intent (not just testing toxicity or pathophysiology);
        iii. Enroll patients with diagnosed disease (except healthy controls in diagnostic trials).
2. Clinical Trials must also meet the following characteristics to be considered medically necessary for the members:
    a. The Aim must be to improve health outcomes;
    b. They must be supported by scientific literature;
    c. They do not create a duplication of existing studies;

d. They must be properly designed and conducted with scientific and regulatory integrity.

3. The Alliance must be responsible for covering the Routine Costs associated with the Clinical Trials. These include:
    a. Standard care patients would receive outside a trial;
    b. Items/services needed to deliver or monitor the ~~investigational~~investigation service;
    c. Treatment/prevention of complications.
4. The Alliance is not responsible for the following costs associated with the clinical trials:
    a. Investigational item/service (unless otherwise covered);
    b. Eligibility screenings not related to medical care;
    c. Extra tests for data collection;
    d. Items/services typically provided free by study sponsors;
    e. Statutorily non-covered services (unless treating complications).

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-400~~019~~ Delegation Oversight.

DEFINITIONS / ACRONYMS

Experimental Service: According to Title 22, CCR, Section 51056.1, an experimental service is any drug, equipment, procedure, or service that is in the testing phase undergoing laboratory and/or animal studies prior to testing in humans.

Investigational Service: According to Title 22, CCR, Section 51056.1, an investigational service is any drug, equipment, procedure, or service for which laboratory and/or animal studies have been completed and for which human studies are in progress but testing is not complete:

a. The efficacy and safety of such services in human subjects is not yet established; and

b. The service is not in wide usage.

Technology Assessment - A process established to evaluate the appropriate use of new technologies, new applications of existing technologies and the organizational or supportive systems within which such care is delivered. Services, procedures, pharmacological treatments, and behavioral health procedures are reviewed.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-400~~019~~ Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

New Policy: 9/17/2025
Updated Policy: 7/28/26

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REFERENCES

CMS National Coverage Determination (NCD) for Routine Costs in Clinical Trials (CMS Pub.100-03, Section 310.1)
NCQA UM 10 Evaluation of New Technology
Title 42, CFR, Section 422.202(b)

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MONITORING

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

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POLICY AND PROCEDURE

Policy Number	QI
Policy Name	NCQA Accreditation Process
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Accreditation Manager
Line(s) of Business	Medi-Cal, Commercial
Effective Date	TBD
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC) / Utilization Management Committee (UMC)
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

This policy establishes a standardized process for planning, managing, documenting, and maintaining accreditation readiness and compliance with applicable National Committee for Quality Assurance (NCQA) standards. The policy ensures consistent governance, timely submission of required materials, effective surveys, and continuous improvement following accreditation outcomes.

PROCEDURE

Standards Monitoring & Change Management

- Standards are monitored semi-annually for any changes.
- Changes are assessed for impact within thirty (30) calendar days and communicated to impacted owners via email.
- Process/policy updates required for compliance are tracked to completion.

Readiness Assessments (Ongoing)

- Readiness assessments occur annually prior to the survey date.
- Gaps are documented in an action tracker with owners, due dates, and evidence of closure.
- High-risk gaps are identified and escalated to leadership within five (5) business days of identification.

Evidence Management (Collection, Control, and Traceability)

- All evidence will be stored in the Accreditation TEAMS channel.
- Evidence must follow naming and version controls.
- An Evidence Crosswalk (tracker) is maintained that maps each standard, element and factors to required evidence and status.
- Evidence must be current, approved (where required), and traceable to source systems/owners.

Self-Assessment / Narrative Development

- The Accreditation Manager performs quality review for completeness, alignment to NCQA standards, and consistency.
- The Health Care Services (HCS) Executive Director or the Quality Improvement Senior Director will review and approval prior to submission.

Submission Process

- All submissions are completed by the Accreditation Manager (or designee) to ensure control and traceability.
- Submissions include the Alliance's NCQA Consultant's approved/final document
- Confirmation of submission receipt is saved in the Accreditation TEAMS channel.

Site Visit / Review Preparation and Execution (only applies to Health Plan Accreditation)

- A site visit plan is created at least 30-60 calendar days prior to the visit and includes:
  - Agenda coordination and logistics
  - Interview schedules and participant preparation
  - Required access to records/systems (as permitted)
  - Debrief following site visit
- Staff involved in interviews receive briefing materials and conduct mock sessions as needed.
- **Findings and Corrective Action**
- Findings (commendations, recommendations, citations, deficiencies) are emailed to the Quality Improvement (QI) Senior Director, Health Care Services (HCS) Executive Director and the Chief Medical Officer (CMO).
- Findings are logged on the tracker on the same day of receipt.
- If there are any findings identified, the Accreditation Team will need to obtain the following for the CAP response form:
  - CAP Standard/Element
  - Description of the Issue
  - Action Step(s)
  - List of Documents provided to show correction
  - Responsible Staff or Department
  - Resources / System Required
  - Internal Metrics / Tracking Plan / QA
  - Barriers to Implementation of corrective action
  - Timeline/dates of planned action
- CAP Survey meeting invite will be sent to the following:
  - Impacted department's Leadership
  - Impacted department's Senior Leadership
  - Accreditation Team members
  - QI Senior Director
  - HCS Executive Director

Commented [MS1]: Who is this? The Department Manager or HCS/QI leadership?

Commented [MS1R2]: Survey?

Commented [MS2]: Add how it will be communicated

Commented [2R2]: Policy has been updated, please review

- CMO

Post-Accreditation Continuous Improvement

- A post-cycle lesson learned review is completed within 60 calendar days.
- Policies, training, and processes are updated based on findings and improvement opportunities.
- Accreditation readiness remains an ongoing operational expectation.

DEFINITIONS / ACRONYMS

Alliance: Alameda Alliance for Health
CAP: Corrective Action Plan
CMO: Chief Medical Officer
HCS: Health Care Services
NCQA: National Committee for Quality Assurance
QI: Quality Improvement

AFFECTED DEPARTMENTS/PARTIES

This policy applies to all staff, departments, programs, and sites involved in accreditation activities, including but not limited to:

- Self-studies, interim reports, annual reporting, and renewals
- Evidence collection, document control, and records retention
- Site visit preparation, coordination, and post-visit response actions
- Ongoing monitoring of standards and corrective action plans

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION APPROVAL HISTORY

TBD

REFERENCES

NCQA Health Plan Standards
NCQA Health Outcomes Standards

MONITORING

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