Policy Procedures Summary of Changes

Policy	Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update (X)	New Policy (X)	Annual Review or Formatting Changes (X)
1	Quality Improvement	QI-101	Quality Improvement Health Equity Program	Describes the Alliance Quality Improvement Health Equity program, including development, implementation, monitoring, and delivery of quality and equitable health care services.	-Modified to comply with All Plan Letter 24-004 Quality Improvement Health Equity Transformation Requirements: 1) alignment with the DHCS Comprehesive Quality Strategy Report and review of DHCS reports: Health Disparity Report, Preventive Care Report, 2) participation in the DHCS' Regional Quality and Health Equity teams. -Modified to comply with DMHC APL 24-013 Health Equity and Quality Program Policies and Requirements: 1) reporting of health equity and quality measure sets (HEQMS)	x		
2	Quality Improvement	QI-111	Delegation of Management and Oversight	Describes the oversight of delegates for QI to ensure a systematic and effective Quality Improvement Health Equity (QIHE) program consistent with regulatory and contractual standards	none			X
3	Quality Improvement	QI-119	Provider Preventable Conditions (PPC) and Adverse Events	Describes the process by which PPCs are identified, processed, investigated, and reported to the DHCS. Medi-Cal managed care plans are prohibited from permitting payment of Medicaid providers for treatment of PPCs (except when the PPC existed prior to the initiation of treatment for that beneficiary by that provider).	None			X
4	Quality Improvement	QI-105	Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility ReviewSurveys (PARS)	Outlines the Alliance site review process, including Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review (PARS), and the process by which Alliance conducts, scores, monitors, and reports site reviews in accordance with all applicable state and federal guidelines	-Modified for the following: 1) Revised from HCQC to QIHEC 2) Given the transition to a single plan model, deleted references to the coordination with other counties for site reviews in Alameda County	x		
5	PHM	003	Risk Stratification and Segementation	Describes Alliance Population Health Management data sources and processes for risk stratification and segmentation of members.	Updated to align with DHCS PHM Policy Guide to additionally include utilization, care management, and eligiblity data in capturing high-risk tier members.	X		x
6	Behavioral Health	BH-004/UM-062	Behavioral Health Treatment		Please retire UM-062 Policy. The BH Department implemented a new policy, BH-004 Behavioral Health Therapies (BHT): Applied Behavioral Health Analysis (ABA), on 04/10/2024. Please refer to the new policy.	X		
7	Quality Improvement	QI-108	Access to Behavioral Health Services	Describes the access and availability standards applicable to behavioral health services provided by the Alliance	Removed verbiage related to delegation of behavioral health services	x		

Policy Procedures Summary of Changes

8	CMDM	UM 16	Transportation Guidelines	Structure of Plan's Transportation Benefit	Addition of langugage regarding transportation for trips outside of time and distance standards, covered by our PA process for trips over 50 miles. Addition of langugage regarding reimbursement of OON trips for IHCP members.	X		
9	CMDM	CM-004	Care Coordination of Services	Structure of Plan's Care Coordination Services	Update to screenshot of CMDM referral form.	X		
10	CMDM	CM-005	Disease Management Programs	Identification, screening, risk stratification, enrollment, assessment, care plan development and management, evaluation and closure for disease management programs	revised to be in alignment with PHM policy guide requirements	X		
11	CMDM	CM-008	SPD HRA - Survey and Interventions	Structure of Health Risk Assessment (HRA) and Procedure for Seniors and Persons with Disabilities (SPD)	Member Adivsory Committee (MAC) changed to Community Advisory Committee (CAC).	X		
12	CMDM	CM-020	Health Information Form Member Evaluation Tool (HIF/MET)	Description of Plan's HIF/MET assessment tool and processing of responses.	N/A			X
13	CMDM	CM-021	Community Supports - Asthma Remediation	Member identification, referring, continuity of care, authoirzation process, data sharing, payment, eligibility, restrictions/limitations and discontining of Asthma Remediation services	Change in department and policy numbering from CM-021 to CS-005	X		
14	CMDM	CM-022	Community Supports - Housing Deposits	Member identification, referring, continuity of care, authoirzation process, data sharing, payment, eligibility, restrictions/limitations and discontining of Housing Deposits services	Change in department and policy numbering from CM-022 to CS-003	X		
15	CMDM	CM-023	Community Supports - Housing Tenancy and Sustaining Services	Maintaining safe and stable tenancy to members once housing is secured	Change in department policy numbers from CM-023 to CS-004	X		
16	CMDM	CM-024	Community Supports - Housing Transition Navigation Services	Assisting members with housing transition and navigation services	Change in department policy numbers from CM-024 to CS-002	X		
17	CMDM	CM-025	Community Supports - Medically Supportive Food/Meals/Medically Tailored Meals	Providing members with medically supportive food/medically tailored meals	Change in department policy numbers from CM-025 to CS-007	X		
18	CMDM	CM-026	Community Supports - Recuperative Care (Medical Respite)	Provide interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral condition	Change in department policy numbers from CM-026 to CS-006	X		
19	CMDM	CM-027	Community Supports - Oversight, Monitoring & Controls	Auditing and oversight of Community Supports provider activities	Change in department policy numbers from CM-027 to CS-001	X		
20	CMDM	CM-029	Developmental Disabilites	Case Management for members with developmental disabilities including division of responsbilites with RCEB	N/A			X
21	CMDM	CM-033	Home and Community Based Services (Waiver Programs) - DDS	Identification and Referral of Members into HCBS waiver programs	N/A			X
22	CMDM	CM-035	Community Supports - Respite Services	Services provided to caregivers of members who require intermittent temporary supervision.	Change in department policy numbers from CM-035 to CS-008	X		

23	CMDM	CM-036	Community Supports - Personal Care & Homemaker Services	Provided for members who need assistance with ADLs. They can also include assistance with IADLs.	Change in department policy numbers from CM-036 to CS-009	X		
24	CMDM	CM-037	Community Supports - Environmental Accessibility Adaptions (Home Modifications	Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the member or enable the member to function with greater independence in the home	change in department policy numbers from CM-037 to CS-010	X		
25	CMDM	CM-038	Community Supports - Nursing Facility Transition/Diversion to Assisted Living Facilities	Assist members to live in the community and/or avoid institutationalization when possible	change in department policy numbers from CM-038 to CS-011	X		
26	CMDM	CM-039	Community Supports - Transition Services/Nursing Facility Transition to a Home	Assist members to live in the community and avoid further institutionalization	change in department policy numbers from CM-039 to CS-012	X		
27	CMDM	CM-040	Community Supports - Sobering Centers	Alternative destinations for members who are found to be publicly intoxicated and would otherwise be transported to the emergency department or jail.	change in department policy numbers from CM-040 to CS-013	X		
28	CMDM	HCS-015	Enhanced Care Management - Outreach/Member Engagement	Member outreach and engagement into ECM program	change in department policy numbers from HCS-015 to CM-041 minor edits to better reflect current processes	X		
29	CMDM	HCS-020	Enhanced Care Management - IT/Data Sharing	IT and data sharing for ECM program between AAH and ECM providers and DHCS requirements	change in departmetn policy numbers from HCS-020 to CM-042	X		
30	UM	UM 001	Utilization Management Program	UM Program details, staff responsibilities, protocols, and UM Hiearchy	Expanded role of the consultants to assist with non-covered benefits reviews and when there are no criteria available from DHCS Provider Manual or MCG, and readily available to the Medical Director Reviewer.	X		
31	UM	UM 046	Use of Board Certified Consultants	Licensing, scope and function of Board Certified Consulants.	Expanded role of the consultants to assist with non-covered benefits reviews and when there are no criteria available from DHCS Provider Manual or MCG, and readily available to the Medical Director Reviewer.	X		
32	UM	CBAS- 001	Initial Member Assessments and Reassessments for Community Based Adult Services Eligibility	Basic policy related to the initiation of CBAS Services	Annual Review- Dates Updated. Updated Dates/ Time frames for Member and provider notifications, fixed grammar/ capitalization. Updated reference resources.	X		X
33	PHM	PHM-003	Risk Stratification and Segementation	Describes Alliance Population Health Management data sources and processes for risk stratification and segmentation of members.	Updated to align with DHCS PHM Policy Guide to additionally include utilization, care management, and eligiblity data in capturing high-risk tier members.	X		X

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POLICY AND PROCEDURE

Policy Number	QI-101
Policy Name	Quality Improvement and Health Equity Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality Improvement
Line(s) of Business	Medi-Cal, GroupCare
Original Effective Date	9/28/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/17/2023
Compliance Committee Approval Date	12/19/2023

POLICY STATEMENT

This policy ensures the development and implementation of a Quality Improvement and Health Equity (QIHE) Program, and the appropriate monitoring of the adequacy, accuracy, accountability and activities of the functions conducted as part of the QIHE Program. Alameda Alliance for Health (the Alliance) continuously monitors, evaluates, and takes action to address any needed improvements in the quality of care and health equity in its network. The QIHE Program is an organizational-wide, cross-divisional and comprehensive program that encompasses the Alliance's commitment to the delivery of quality and equitable health care services including the integration of quality, population health, and health equity principles.

The QIHE Program exists to assure and improve the quality of care for Alliance members, in fulfillment of California Department of Health Care Services (DHCS) requirements, Title 28, California Code of Regulations, Section 1300.70, and Title 42, Code of Federal Regulations, Section 438.330 and 438.340. Additionally, QIHE Program oversight entities may electively incorporate best practice standards (e.g., National Committee for Quality Assurance [NCQA] standards) into the QIHE Program.

PROCEDURE

A. Scope

The Alliance ensures that Network Providers, Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors (if an existing contract exists), participates and are updated on the QIHE Program and Population Needs Assessment activities, findings, and recommendations by the Quality Improvement Health Equity Committee (QIHEC). The QIHE Program

encompasses quality of care, quality of services, patient safety, member experience, including health equity principles.

B. Board of Governors (BOG)

1. The Alliance's Board of Governors (BOG) maintains the ultimate authority and responsibility for the QIHE Program.
2. The BOG assesses the QIHE Program's effectiveness and direct modification of operations as indicated.
3. The Alliance BOG approves the overall QIHE Program and has delegated the QIHEC to oversee the QIHE Program.
4. The BOG routinely receives written progress reports from QIHE describing actions taken, progress in meeting QIHE Program objectives, and improvements made.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC oversees the development, implementation, and effectiveness of the QIHE Program and is accountable to the BOG. The activities are supervised by the Chief Medical Officer (CMO) and Medical Director of Quality, in collaboration with the Chief Health Equity Officer. The QIHEC oversees subcommittees and workgroups including, Population Health, Access and Availability, Cultural and Linguistic, Internal Quality, and the Utilization Management Committees. The QIHEC is chaired by the Chief Medical Officer (CMO) and vice-chaired by the Medical Director of Quality.

The QIHEC is responsible for the following activities:

a. Recommends policy decisions
b. Analyzes, evaluates, and provides feedback on the results of QIHE activities
c. Ensures practitioner participation in the QIHE Program through planning, design, implementation or review
d. Recommends needed actions
e. Ensures follow-up, as appropriate
f. Maintains signed and dated meeting minutes
g. Review and approve the QI Trilogy Documents including the QIHE Program Description, Evaluation, and Workplan
h. Review and approve the CM Trilogy Documents including the QIHE Program Description, Evaluation, and Workplan
i. Review and approve the UM Trilogy Documents including the QIHE Program Description, Evaluation, and Workplan

5. The QIHEC meets a minimum of four times per year or as often as needed, to follow-up on findings and required actions.
6. For all meetings, the Senior Director of Quality will submit signed QIHEC meeting minutes to the department of Compliance for submission to the Department Health Care Services (DHCS).
7. A written summary of the QIHEC activities, findings, recommendations , and actions are provided to the BOG, DHCS upon request, and made publicly available on the website at least on a quarterly basis.
8. QIHEC members are representative of the contracted provider network, including but not limited to, subcontractors who provide health care services to the plan's members including, seniors and persons with disabilities or chronic conditions (SPDs), members affected by health disparities, Limited English Proficiency (LEP), and Children with Special Health Care Needs (CSHCN).

9. All providers participating in the QIHEC or any of its subcommittees, or other QIHE program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements.

C. QIHE Program Description

1. On an annual basis, the BOG and QIHEC will review and approve a comprehensive QIHE Program Description. This description will include at a minimum, the following:

a. QIHE Program scope, goals and measurable objectives

~~a.~~

b. QIHE Program structure
c. Organizational chart showing the key staff and the committees and governing bodies responsible for quality improvement activities
d. Qualifications of staff responsible for QIHE studies and activities
e. Behavioral health aspects of the program
f. How patient safety is addressed
g. The governing body of the QIHE Program
h. Involvement of a designated physician in the QIHE Program
i. Involvement of a behavioral health practitioner in the mental health aspects of the program
j. Oversight of QIHE functions by the QIHE Committee
k. The specific role, structure and function of the QIHE Committee and other committees, including meeting frequency
l. An annual work plan
m. The resources and analytic support devoted to the QIHE Program
n. Objectives for serving a culturally and linguistically diverse membership
o. Objectives for serving members with complex health needs
p. Incorporates how members and/or parents and caregivers are engaged in the development of QI and health equity activities and interventions
q. The processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, or health status, and that all covered services are provided in a culturally and linguistically appropriate manner
r. Incorporates identifying, evaluating and reducing Health Disparities, in parallel with the Population Health Management Program
s. Analyzes data to identify differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to members
t. Develop equity-focused interventions to address the underlying factors of identified Health Disparities, including Social Drivers Of Health (SDOH).
u. Meet disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A.III Subsection 2.2.9.A.
v. Description of the activities, including activities used by members that are seniors and persons with disabilities or persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

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w. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.

x. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.

~~x.~~y. Alignment with health equity goals with DHCS' Health Equity Framework within the Comprehensive Quality Strategy (CQS) Report, and stratify DHCS-selected MCAS measures by various demographics

D. QIHE Communications

1. The Alliance annually makes information about the QIHE Program and results available to members through an annual notification in the member newsletter directing members to the Alliance website, and providing information to members on how to obtain information about the QIHE Program and results if they are not able to access the website.
2. The Alliance publishes articles about the QIHE Program, activities, and outcomes in the Provider Bulletin for practitioners. The articles also direct practitioners to the Alliance website for additional information on the QIHE Program. The QIHE Program information is also available in the Provider Manual.

E. QIHE Work Plan and Evaluation

1. The Quality Department will prepare an annual QIHE Work Plan that addresses the following:
   a. An assessment of the QIHE activities, an evaluation of areas of success, and an evaluation of areas that need improvements in services rendered within the QIHE Program. These areas may include data on performance measures and utilization, the results of the Managed Care Accountability Sets (MCAS), outcomes/findings from Quality Improvement Projects (QIPs), DHCS Performance Improvement Projects (PIPs), consumer satisfaction surveys, collaborative initiatives, and findings and activities from other committees, such as ~~Member~~ Consumer Advisory Committee
   b. Addresses clinical quality of physical, behavioral health, access and engagement of providers continuity and coordination across settings and all levels of care, and member experience
   ~~b.~~c. Quality of Care
   ~~c.~~d. Quality of Service
   ~~d.~~e. Safety of Clinical Care
   ~~e.~~f. Program Scope
   ~~f.~~g. Annual Objectives / Goals
   ~~g.~~h. Annual Planned Activities
   ~~h.~~i. Time Frames within which each activity is to be achieved
   ~~i.~~j. Staff member responsible for each activity
   ~~j.~~k. Monitoring previously identified issues

2. The Quality Improvement Department are made up of Clinical Quality, Access and Availability, Health Education, Population Health, and Cultural and Linguistic

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Services will prepare an annual written evaluation of the QIHE Program that includes:

a. A description of completed and ongoing QIHE activities that address quality, health disparities and equity and safety of clinical care and quality of service
b. Trending of measures to assess performance in the quality and safety of clinical care and quality of service
c. Analysis of the results of QIHE initiatives, including barrier analysis
d. Evaluation of the overall effectiveness of the QIHE Program, including progress toward influencing safe clinical practices
e. Methods to address External Quality Review technical report and evaluation report recommendations.
f. Methods for equity-focused interventions to identify patterns for over- or under-utilization of physical and behavioral health care services

3. On an annual basis, accreditation status will be reported to QIHEC including copies of reports from independent private agencies for the Alliance, Subcontractors, and Downstream Subcontractors by providing accreditation status, survey type, level, accreditation agency results and recommended actions/improvements, corrective action plans, and summaries, along with accreditation expiration date.

4. The QIHEC and BOG will annually review and approve the QIHE Work Plan and QIHE Program Evaluation

Quality Monitoring Activities

The Alliance aligns internal quality and health equity efforts with DHCS' Comprehensive Quality Strategy Report, monitor and report quality performance measures, and also review and act on items identified through DHCS' reports.

The Alliance participates in DHCS mandated statewide collaborations or additional initiatives that may improve quality and equity of care for Medi-Cal members as directed by DHCS. The Alliance will leverage DHCS' Regional Quality and Health Equity teams to support quality and health equity work. The Alliance has assigned a Performance Improvement Lead and a back up contact to participate in these teams and report performance measurements to DHCS.

As applicable, the Alliance uses the DHCS' External Quality Review Organization (EQRO) File Transfer Protocol (FTP) website when sending communications containing patient-level data to DHCS.

F. Managed Care Accountability Sets (MCAS) and HEDIS

1. The Alliance will calculate and report all HEDIS measures and other quality and health equity performance measures as specified by DHCS, DMHC, CMS and NCQA.
2. The results of these performance measures shall be audited by an external MCAS/HEDIS Compliance Auditor.
~~2.~~3. The Alliance is required to conduct additional Quality Improvement and health equity improvement projects as determined in the MCAS: Quality Improvement and Health Equity Framework Policy Guide

G. Quality Improvement and Health Equity Projects

1. Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs) ~~and Performance Improvement Projects (PIPs)~~
   ~~a.~~ The Alliance will conduct a minimum of two ~~DHCS~~ Performance Improvement Projects (PIPs) or Quality Improvement Projects (QIPs) as mandated by Centers for Medicare and Medicaid or DHCS. ~~well as Quality Improvement Projects (QIPs).~~
   ~~i.~~a. One PIP may be a DHCS facilitated statewide collaborative.
   b. The Alliance reports audited results on the required performance measures to DHCS.
   ~~b.~~c. The Alliance attends, at a minimum, quarterly regional collaborative meetings that may be in person
2. The Alliance shall identify opportunities for QIPs/PIPs through meetings, data analysis, HEDIS assessments, and day-to-day operations.
3. The Alliance will engage with local partners and delegates when developing interventions and strategies to address deficiencies in performance measures related to Members less than 21 years of age.
4. The Alliance will comply with MMCD All Plan letter ~~19-017~~24-004 and subsequent updates and shall use the QIP reporting format as designated by DHCS.
5. The Alliance conducts quantitative and qualitative data collection to drive quality improvement and health equity projects.
6. The Alliance drives performance improvement projects to exceed Minimum Performance Level (MPL) rates for each required Quality Performance Measures and Health Equity Measure selected by DHCS.

H. Consumer Satisfaction Survey

The Alliance conducts annual member satisfaction survey in accordance with Consumer Assessment of Health Providers and Systems 5.1H (CAHPS) survey methodology, that comply with DHCS APL17-014, with the DHCS contract, exhibit A, attachment 5, section 1.G., and with Title 42, Code of Federal Regulations, section 423.156. Refer to policy QI-117 Member Satisfaction Survey (CAHPS)

I. Network Adequacy Validation

The Alliance participates in the EQRO's validation of Contractor's Network adequacy representations from the preceding 12 months in compliance with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358. Refer to policy PRV-003 *Provider Network Capacity Standards.*

J. Encounter Data Validation

The Alliance participates in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.242(d), and 438.818.

K. Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Quality Assurance Performance Improvement (QAPI)

The Alliance maintains a comprehensive SNF/LTC QAPI program to comply with APL 23-004 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care and described in policy LTC- 001 *Long Term*

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Care Program. In addition, the Alliance maintains a quality monitoring program to comply with APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities.

L. Focused Studies

The Alliance participates in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided by Contractor.

M. Health Disparities Report

The Alliance references the DHCS' Health Disparities report that describes health disparities in the Medi-Cal population to inform QIHE activities.

N. Preventive Services Report

The Alliance references the DHCS' Preventive Services report that describes preventive services in the Medi-Cal population to inform QIHE activities.

~~M.~~O. Technical Assistance

The Alliance participates in mandatory and optional activities described in 42 CFR section 438.358 and this Contract.

~~N.~~P. Site Review

The Alliance conducts site review requirements as described in policy QI -105 *Facility site Reviews, Medical Record Reviews, and Physical Accessibility Reviews.* Other types of site or medical reviews may be conducted as required by DHCS or for quality monitoring purposes.

~~O.~~Q. Potential Quality Issue (PQI)

The Alliance conducts PQI monitoring processes as described in policy QI-104 *Potential Quality Issues*

R. Health Equity and Quality Measure Set (HEQMS)

The Alliance reports health equity and quality measure sets (HEQMS) as required by the Department of Managed Health Care (DMHC) as described in APL 24-013 Health Equity and Quality Program Policies and Requirements

S. Other quality monitoring activities as required by QIHEC or mandated by State and Federal laws and regulations

AFFECTED DEPARTMENTS/PARTIES

All Alliance departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Quality Improvement Health Equity Program Description
Quality Improvement Health Equity Work Plan
Quality Improvement Health Equity Program Evaluation
QI-117 Member Satisfaction Survey (CAHPS)
PRV-003 Provider Network Capacity Standards.
LTC- 001 Long Term Care Program
QI -105 Facility site Reviews, Medical Record Reviews, and Physical Accessibility Reviews.

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REVISION HISTORY

9/28/2006, 7/13/2007, 1/1/2008, 10/28/2009, 2/26/2010, 9/18/2012, 11/6/2014, 11/10/2016, 10/18/2018, 3/21/19, 3/19/2020, 3/22/2022, 3/31/2023, 6/20/2023, 12/19/2023, 7/5/2024

REFERENCES

DHCS Medi-Cal Contract Exhibit A, Attachment 3
~~MMCD All Plan letter 19-017~~
MMCD All Plan Letter 23-004 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
MMCD APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities
MMCD All Plan Letter 24-004 Quality Improvement Health Equity Transformation Requirements
DMHC APL 24-013 Health Equity and Quality Program Policies and Requirements

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MONITORING

This policy will be reviewed annually to ensure effectiveness.

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POLICY AND PROCEDURE

Policy Number	QI-111
Policy Name	Delegation of Management and Oversight
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality Improvement
Line(s) of Business	Medi-Cal, GroupCare
Effective Date	4/13/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	6/20/2023

POLICY STATEMENT

The Alliance is responsible for the oversight of delegated Quality Improvement (QI) responsibilities. The Alliance ensures the delegate has a systematic and effective Quality Improvement Health Equity (QIHE) program for providing and evaluating access to quality healthcare services provided to Alliance members which is consistent with regulatory and contractual standards. Delegated entities are required to have certain QIHE components and functions in adherence to Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and the Alliance standards outlined in the Reference section of this Policy and Procedure.

The Alliance has established the appropriate structure and mechanism to perform oversight of delegate's Quality Management and Utilization Management delegation activities to ensure compliance with regulatory and contractual requirements. The Alliance performs a capability assessment prior to delegation, and annually assesses delegates thereafter to monitor performance, corrective actions, and provide recommendations for improvement.

A mutually agreed upon delegated contractual agreement outlines the QIHE responsibilities for the delegate entity and the Alliance. This may include delegation of Quality Management, Utilization Management, Credentialing, and Member Grievances and Appeals.

The Alliance reserves the right to revoke delegate responsibilities or terminate the delegate's contract if the delegate fails to meet the Alliance's contractual delegation agreement requirement.

PROCEDURE

A. The Alliance audits each delegate prior to contracting to evaluate if the delegate's capacity meets DHCS, DMHC, NCQA, and Alliance requirements. The Alliance reviews the delegate's written policies and procedures, program descriptions, and activities under consideration. The results of the pre-delegation assessment are reviewed by the QI Department and forwarded to the Quality Improvement Health Equity Committee (QIHEC) for determination of delegation status.

B. The Alliance will establish a mutually agreed upon delegation agreement with the delegated entity to include QIHE responsibilities and reporting activities required by the delegate, and the oversight and monitoring responsibilities and process of the Alliance. Additionally, the delegation agreement describes the remedies and actions taken by the Alliance if obligations are not fulfilled by the delegate. This agreement also specifies the semi-annual, or more frequent, reporting requirements of the delegate as deemed appropriate by the Alliance.

C. For delegation agreements in effect for 12 months or longer, the Alliance performs annual delegation oversight audit to verify compliance with the Alliance requirements and their continued ability to perform delegated functions. The Alliance evaluates the following delegation activities (depending if the areas are applicable to the delegate's contracted responsibilities) annually through the delegation oversight audit, which includes, but is not limited to:

1. QIHE program, work plan and evaluation
2. Utilization Management (UM) program
3. QI and UM policies and procedures
   a) Including but not limited to inpatient hospital services, outpatient care, referral program, prior authorization process, over/underutilization, coordination in care, facility site reviews, medical records, mental health services if applicable
4. QIHE/UM committee meeting minutes
5. Complex case management case file review
6. Authorization denial and appeal case file review
7. Complex case management case file review
8. Access and availability
   b) Timely access to primary care, specialist, ancillary support services, laboratory services, mental health services if applicable
9. Credentialing
10. Preventative health services
11. Member rights and responsibilities
12. Grievances, appeals, and potential quality issues (PQIs)
13. California Children Services (CCS)
14. Cultural and Linguistic Services
15. Member and Provider Health Education
16. Delegation activity reporting
17. Follow-up of any issues found within the last year's delegation reporting and last

year's audit

D. Through the annual delegation oversight audit, the Alliance will assess the delegated activities and score the delegate's performance. The annual review may include a review of files related to the area being evaluated. If there are findings or opportunities for improvement, the Alliance will issue a written corrective action plan (CAP) with recommendations for improvement to the delegate. The delegate will have 30 calendar days to provide responses to the CAP issued by the Alliance. The Alliance will evaluate if deficiencies were corrected, and follow-up on the actions until all deficiencies are resolved. The delegation audits will review past findings to ensure policy and procedure changes have been effective and evaluate if there are any repeated findings.

E. Focused audits may occur between annual audits if the Alliance determines the need to evaluate the delegate's performance in specific areas. Periodic site visits to the delegate may occur at any time of the year for oversight auditing purposes.

F. Delegates are required to report QI and UM data to the Alliance on a quarterly and annual basis. Delegation reports are reviewed by the Alliance applicable departments to ensure compliance standards are being met. Any deficiencies cited by the Department(s) are communicated to the Delegate through a written CAP. The delegate receives a timeframe to respond to the CAP. Delegation reports are reviewed by the Compliance Committee and forwarded to Quality Improvement Health Equity (QIHE) committee for review. All delegation oversight activities are reported to the QIHE committee for review and recommendations.

G. As part of its relationship with the delegate, the Alliance provides the following information to the delegate when requested:

1. Member experience data (if relevant) – this information is data that is collected by the Alliance that reflects the member experience with the Alliance and the delegate. This can include surveys and complaint data. This information is used to improve the member experience within the plan and the delegate's services.
2. Clinical performance data – this information is data from claims and other clinical analysis that can be used to assess and improve quality of care and access to preventive and needed care.
3. Delegates may request this information on an ad hoc or routine basis. When possible, the Alliance will share performance data at the quarterly Joint Operations Meetings.

H. Delegated Providers, who consistently fail to meet Alliance standards, as confirmed through annual and/or focused audits, reporting, or other oversight activities, are subject to actions up to and including:

a. Rescission of delegated functions,

b. Non-renewal of the Alliance contract, or

c. Termination of the participation in the Alliance network

DEFINITIONS / ACRONYMS

AFFECTED DEPARTMENTS / PARTIES

Grievance and Appeals
Compliance
Credentialing
Member Services
Quality Improvement
Utilization Management

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
CMP-020 Corrective Action Plan
CRE-002 Credentialing and Recredentialing of Individual Practitioners
CRE-009 Ongoing Monitoring of Practitioners
QI-101 Quality Improvement Program
QI-104 Potential Quality Issues
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REVISION HISTORY

6/16/2016, 3/1/2018, 5/3/2018, 3/21/19, 4/15/2020, 5/21/2020, 6/28/2022, 6/20/2023

REFERENCES

DHCS Contract, Exhibit A, Attachment 4, Section 6
Title 28, CCR 1300.70(b)(2)(G)
NCQA 2018 Standards and Guidelines for the
Association of Health Plans, Quality Management
and Improvement, QI 7, Element A-F

MONITORING

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

POLICY AND PROCEDURE

Policy Number	QI-119
Policy Name	Provider Preventable Conditions (PPC) and Adverse Events
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Sr. Director of Quality
Line(s) of Business	Medi-Cal, Group Care
Effective Date	11/21/2006
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	6/20/2023

Purpose:

To define the process by which Provider Preventable Conditions (PPCs) are identified, processed, investigated, and reported to the Department of Health Care Services (DHCS). Pursuant to the 2010 Federal Affordable Care Act section 2702 and Title 42 of the Code of Federal Regulations (CFR), section 447.26, 434.6(a)(12)(i), and 438.3(g) and Welfare and Institutions Code Section 14131.11, Medi-Cal managed care plans are prohibited from permitting payment of Medicaid providers for treatment of PPCs (except when the PPC existed prior to the initiation of treatment for that beneficiary by that provider). PPC's include both the "Health Care Acquired Conditions" (HCACs) defined in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act and Other Provider Preventable Conditions" (OPPCs). Furthermore, the federal Centers for Medicare & Medicaid Services (CMS) specifies that managed care organizations must participate in reporting PPC related encounters.

Policy:

Alameda Alliance for Health (the Alliance) maintains systematic processes to:

A. Promote quality care and member safety and minimize loss through;
    a. decreasing the frequency and severity of adverse events
    b. risk identification, evaluation, and management.

B. Identify, report, and manage adverse events to ensure that appropriate care is delivered during surveillance for and correction of material causes for these events.

Procedure:

1. Reporting Requirements

A. Alameda Alliance for Health (the Alliance) requires all contracted providers and facilities to report all PPCs for Medi-Cal members to the Department of Health Care Services (DHCS) via DHCS' secure online reporting portal. This applies to all PPCs not present on admission (POA) or at the time of initial treatment at a healthcare facility.
B. Alliance providers must report all PPC occurrences for Medi-Cal members directly to the Alliance using the PPC reporting form. Reporting must be made within five (5) working days of PPC discovery.
C. The Alliance notifies providers of this reporting requirement via the Alliance Provider Manual and special notices.
D. It is the policy of the Alliance to identify claims and encounter data containing PPC diagnoses and report this information to DHCS via the secure online reporting portal per the requirements of APL 17-009: Reporting Requirements Related to Provider Preventable Conditions.

2. Screening of Claims/Encounter Data

A. Alliance Analytics Department runs a monthly report to monitor facility claims/encounters with Present on Admission (POA) indicators that contain a N, W, U or blank. Per Medi-Cal guidelines, these indicator values are to be considered as not present on admission.

The report that indicates a paid claim with a POA indicator that was not present on admission is reviewed for possible recoupment.

3. Clinical Review and Reporting of Potential PPCs

A. Potential PPCs reported to Quality from Claims, Utilization or Case Management, or discovered in the course of a PQI investigation will be reviewed to validate whether a reported incident meets the definition of a PPC. Refer to TERMS/ACRONYMS/DEFINITIONS section of this policy
B. The scope of the PPC review by Quality shall include but not be limited to, both a medical record and claims history review.
C. The potential PPC will be reviewed by the QI Nurse Reviewer to determine if the case is a potential quality issue (PQI) and will need to go through the PQI review process (see policy QI-104).
D. All potential PPCs are forwarded to the Chief Medical Officer or physician designee for secondary review and final PPC validation.
E. Medical Director validated PPC cases may be presented to and reviewed by the Peer Review Committee (PRC) for comment and/or any corrective actions (see policy QI-104).
F. Findings of all potential PPC investigated cases will be reported to the claims department

designee.

G. Notification of the reported incidents is also sent to the Alliance internal Compliance Department.

5. Payment Recoupment for Confirmed PPCs

A. The Claims department will follow the CLM-008 Overpayment Recovery policy and procedures for claims that have a POA indicator of not present on admission and associated payments will be reviewed for possible recoupment.

6. Document Retention

Copies of any PPC submissions to DHCS by the Alliance and supporting medical record evidence, as well as claims/encounter data shall be maintained in accordance with Alliance P&P CMP-012 Record Retention.

TERMS/ACRONYMS/DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below:

1. **Adverse Event** - Any unintentional, undesirable injury to a member/patient resulting from a medical intervention.

2. **Encounter** - Any single medically related service rendered by (a) medical provider(s) to a Member enrolled in Alameda Alliance for Health during the date of service. It includes, but is not limited to, all services for which the Alliance incurred any financial liability

3. **Health Care Acquired Conditions (HCACs)** - As defined in Tile 42 of the Code of Federal Regulations (C.F.R), Section 447.26(b), any one of the following conditions, occurring in any inpatient hospital setting, identified as a Hospital Acquired Condition (HAC) by the Secretary under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act.
    a. Any unintended foreign object retained after surgery
    b. A clinically significant air embolism
    c. An incidence of blood incompatibility
    d. A stage III or stage IV pressure ulcer that developed during the patient's stay in the hospital
    e. A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock
    f. A catheter-associated urinary tract infection
    g. Any of the following manifestations of poor glycemic control: diabetic ketoacidosis; nonketotic hyperosmolar coma; hypoglycemic coma; secondary diabetes with ketoacidosis; or secondary diabetes with hyperosmolarity

h. A surgical site infection following:
    i. Coronary artery bypass graft (CABG) - mediastinitis Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery
    ii. Orthopedic procedures; including spine, neck, shoulder, elbow
    iii. Cardiac implantable electronic device procedures
i. Deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement with pediatric and obstetric exceptions
j. Iatrogenic pneumothorax with venous catheterization
k. A vascular catheter-associated infection

4. **Provider Preventable Condition (PPC) -** A condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition," as defined in 42 CFR 447.26(b)

5. **Sentinel Event** - Any unexpected occurrence involving death or serious physical or psychological injury or the risk thereof defined as any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

6. **Other Provider Preventable Conditions (OPPCs)** - As defined in 42 CFR 447.26, a condition occurring in any health care setting that meets the following criteria:
    a. Is identified by the State Plan;
    b. Is reasonably preventable through the application of procedures supported by evidence-based guidelines.
    c. Has negative consequences for the Member.
    d. Is auditable; and
    e. Includes, at a minimum, the following procedures:
    f. Wrong surgical or other invasive procedure performed on a patient.
    g. Surgical or other invasive procedure performed on the wrong body part.
    h. Surgical or other invasive procedure performed on the wrong patient.

AFFECTED DEPARTMENTS/PARTIES

Claims
Compliance
Credentialing
Grievances & Appeals
Member Services
Pharmacy
Provider Relations Department Quality Improvement
Utilization Management Department

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Program
QI-104 Potential Quality Issues
CMP-012 Record Retention
CLM-08 Overpayment Recovery

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2006, 1/1/2008, 10/28/2009, 2/26/2010, 12/10/2012, 1/18/2013, 11/6/2014, 1/7/2015, 2/11/15, 12/15/16, 4/12/2018, 01/21/2021,01/20/2021, 03/22/2022, 6/20/2023

REFERENCES

Affordable Care Act of 2010 (ACA) Section 2702 DHS Contract Attachment 4, Sec. 1-9
42CFR, Section 434.6, 438.3 and 447.26, §I.H.
DHCS All Plan Letter 17-009 Reporting Requirements Related to Provider Preventable Conditions

MONITORING

This policy will be reviewed annually to ensure effectiveness.

State of California - Health and Human Services Agency Department of Health Care Services

Medi-Cal Provider-Preventable Conditions (PPC) Reporting Form

1. Name of facility		1 2. National Provider Identifier (NPI):
3. Type of facility:	0 In-patient	0 Outpatient
4. Address:		
City:	State:	Zio code:

By law, providers must identify provider-preventable conditions that are associated with claims for Medi-Cal payment or with courses of treatment furnished to Medi-Cal patients for which Medi-Cal payments would otherwise be available. See instructions for a more detailed description of PPCs.

PPC-Other Provider-Preventable Condition(OPPC) in any health care setting:	
5. Date of OPPC:	
6. D Wrong surgery/invasive procedure	
7. O Surgery/invasive procedure on the wrong body part	
8. O Surgery/invasive procedure on the wrong patient	
PPC-Health Care-Acquired Conditions(HCAC) in an acute inpatient setting:	
9. Date of HCAC:	
10. 0 Air embolism	11. 0 Blood incompatibility
12. 0 Catheter-associated urinary tract infection	13. 0 Deep vein thrombosis/pulmonary embolism
14. 0 Falls/trauma	15. 0Foreignobject retained after surgery
16. O Iatrogenic pneumothorax with venous catheterization	
17. O Manifestations of poor glycemic control	18.0Stage Ill or IV pressure ulcers
19. 0 Surgical site infection	20. 0 Vascular catheter-associated infection
21. Patient under 21 years old? Y O N O	
22. Patient's name:	
23. Client Index Number (CIN):	
24. Does the patient have Managed Care Medi-Cal? Y O N O	
25. Patient's address:	
City: State: Zip Code: Apt.:	
26. Name of person completing report:	
27. Title:	
28. Phone: Email: Fax:	

Signature: ———————————————— Date: ————————————

29. Mark "PROTECTED HEALTH INFORMATION: CONFIDENTIAL" and send completed report related to a Medi-Cal beneficiary within 5 working days of discovery to:

Via Secure Fax

(916) 650-6720 Department of Health Care Services Audits and Investigations Division Occurrence of Provider-Preventable Conditions

Via U.S. Post Office

Department of Health Care Services Occurrence of Provider-Preventable Condition Audits and Investigations Division, MS 2100
P.O. Box 997413
Sacramento, CA 95899-7413

Via UPS, FedEx, or Golden State Overnight

Department of Health Care Services Occurrence of Provider-Preventable Condition Audits and Investigations Division, MS 2100 1500 Capitol Ave., Suite 72.624 Sacramento, CA 95814-5006

INSTRUCTIONS

Providers must complete and send one form for each provider-preventable condition (PPC). Please note that reporting PPCs to the Department of Health Care Se/Vices for a Medi-Cal beneficiary does not preclude the reporting of adverse events and healthcare associated infections (HAis), pursuant to the Health and Safety *Code, to the California Department of Public Health for the same beneficiary. Providers must report any PPC to DHCS that did not exist prior to the provider initiating treatment for* a *Medi-Ca/ beneficiary, even if the provider does not intend to bill Medi- Cal.*

Facility information (boxes 1-4)

1. Enter name of facility where the PPC occurred.
2. Enter the facility's National Provider Identifier (NPI).
3. Check the appropriate box if the PPC occurred in an inpatient or outpatient facility.
4. Enter the street address, city, state, and zip code of the facility where the patient was being treated when the PPC occurred.

PPC - Other Provider-Preventable Condition (boxes 5-8)

5. If reporting an OPPC (inpatient or outpatient), enter the date (mm/dd/yyyy) that the OPPC occurred.
6. Check the box if the provider performed the wrong surgical or other invasive procedure on a patient.
7. Check the box if the provider performed a surgical or other invasive procedure on the wrong body part.
8. Check the box if the provider performed a surgical or other invasive procedure on the wrong patient.

PPC-Health Care-Acquired Condition (boxes9-20)

HCACs are the same conditions as hospital-acquired conditions (HACs) that are reportable for Medicare, with the exception of reporting deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age as noted below.

9. If reporting an HCAC (inpatient only), enter the date (mm/dd/yyyy) that a provider detected the HCAC.
10. Check the box if a patient experienced a clinically significant air embolism.
11. Check the box for an incidence of blood incompatibility.
12. Check the box if a patient experienced a catheter-associated urinary tract infection.
13. Check the box if the patient experienced deep vein thrombosis (DVT) pulmonary embolism (PE) following total knee replacement or hip replacement in an inpatient setting. Do not check the box if the patient was under 21 or pregnant at time of PPC.
14. Check the box if the patient experienced a significant fall or trauma that result in:
    - Fracture
    - Dislocation
    - lntracranial injury
    - Crushing injury
    - Burn
    - Electric shock
15. Check the box for any unintended foreign object retained after surgery.
16. Check the box if the patient experienced iatrogenic pneumothorax with venous catheterization.
17. Check the box if the patient experienced any of the following manifestations of poor glycemic control:
    - Diabetic ketoacidosis
    - Nonketotichyperosmolar coma
    - Hypoglycemic coma
    - Secondary diabetes with ketoacidosis
    - Secondary diabetes with hyperosmolarity
18. Check the box if the patient developed a stage Ill or stage IV pressure ulcer.

19. Check the box if a patient experienced:
    - Mediastinitis following coronary artery bypass graft (CABG)
    - A surgical site infection following o Bariatric surgery
        - Laparoscopic gastric bypass
        - Gastroenterostomy
        - Laparoscopic gastric restrictive surgery
    - A surgical site infection following: *(continued)*
        - o Orthopedic procedures
            - Spine
            - Neck
            - Shoulder
            - Elbow
        - o Cardiac implantable electronic device (CIED) procedures
20. Check the box if a patient experienced a vascular catheter-associated infection.

Patient information (boxes 21-25)

21. Check "yes" if the patient was under 21 years old or "no" if the patient was age 21 or older when the PPC occurred.
22. Enter beneficiary's name (last, first, middle) as listed on the Beneficiary Identification Card.
23. Enter beneficiary's Client Index Number (CIN) from the Beneficiary Identification Card.
24. Check "yes" if the beneficiary receives Medi-Cal through a managed care contract or "no" if the patient has Fee-For-Service (FFS) Medi-Cal.
25. Enter beneficiary's home street address, including city, state, zip code, and apartment number, if applicable.

Provider Contact information (boxes 26·28)

26. Enter the name of the person completing this report.
27. Enter the title of the person completing this report.
28. Enter a work phone number, email address, and fax number where DHCS can contact the person completing this report.

Department of Health Care Services (box 30)

29. Providers must send this form to the Department of Health Care Services (DHCS), Audits and Investigations Division via fax, U.S. Post Office, UPS, or FedEx. Providers must submit the form within five (5) working days of discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. The preferred methods of sending the reports for confidentiality are No. 1, overnight courier with appropriate marking, No. 2, secure fax machine with appropriate marking, and No. 3, U.S. mail with appropriate marking. Providers must comply with HIPAA and any other relevant privacy laws to ensure the confidentiality of patient information.
    Providers may email questions about PPCs to PPCHCAC@dhcs.ca.gov.

THE INFORMATION CONTAINED IN THE COMPLETED FORMS IS *PROTECTED HEALTH INFORMATION AND PERSONALLY IDENTIFIABLE INFORMATION, UNDER FEDERAL (HIPAA) LAWS AND CA STATE PRIVACY LAWS. IT MUST BE SHARED ONLY WITH DHCS' AUDITS AND INVEST/GA TIONS DIVISION. THE PROVIDER IS RESPONSIBLE FOR ENSURING THE CONFIDENTIALITY OF THIS INFORMATION.*

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

POLICY AND PROCEDURE

Policy Number	QI-105
Policy Name	Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS)
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	Medi-Cal, Group Care
Original Effective Date	01/01/2008
Subcommittee Name	~~Health Care~~ Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/19/2023
Compliance Committee Approval Date	6/20/2023

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POLICY STATEMENT

1. This policy outlines Alameda Alliance for Health's ("the Alliance") site review process, including Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review (PARS), and the process by which Alliance conducts, scores, monitors, and reports site reviews in accordance with all applicable state and federal guidelines.

2. The Alliance Chief Medical Officer is responsible for oversight of site review policies in accordance with regulatory requirements. All Alliance contracted and subcontracted Primary Care Provider (PCP) sites must be compliant with applicable local, state, and federal standards related to FSRs. The California Department of Health Care Services (DHCS) only accepts site reviews that are conducted and completed by a Certified Master Trainer (CMT) and/or a Certified Site Reviewer (CSR).

3. The Alliance conducts site review processes to ensure access for people with disabilities in accordance with the protections of the Americans with Disabilities Act of 1990 (42 U.S.C. § 1211 et seq.), Section 504 and 508 of the Rehabilitation Act (29 U.S.C. § 794), 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), SB 223, SB 1423, APL 17-006, and Title 28, Code of Federal Regulations (CFR), section 35.151.

4. The Alliance complies with the DHCS requirement (Contract, All Plan Letter [APL], and Policy Letter [PL]) that the PCPs undergo an initial and subsequent full scope FSR, MRR, and PARS, in order to participate in Medi-Cal managed care, regardless of a PCP site's other accreditations and certifications. Alliance must ensure that:

a) Each PCP site has passed an initial FSR and, as applicable, correct all deficiencies in order to close their Corrective Action Plan (CAP) prior to adding the provider(s) to the Alliance network and assigning members to the provider(s).

b) Each PCP site completes an initial MRR after the PCP is assigned members, and, as applicable, submits all appropriate documentation to address all deficiencies to close their CAP.

c) Each PCP site completes a periodic subsequent site review at least every three (3) years after the initial FSR, consisting of an FSR, MRR, and PARS. The purpose of these subsequent FSRs and MRRs is to evaluate the continuing capacity of the site in supporting the delivery of quality health care services.

d) The most current DHCS FSR and MRR tools and standards are being utilized when conducting site reviews.

e) All PCP sites are held to the same standards.

f) The site review status of each contracted PCP site is properly documented and monitored.

g) For shared providers, Managed Care Plans (MCP) will collaborate locally to determine how they will notify each other of site review statuses and results.

5. The Alliance must issue a Certificate of Completion to providers that successfully complete both the FSR and MRR and close all CAPs.

    a) This certificate is dated based on the most recent FSR, is valid for up to three (3) years, and affirms that the site has been deemed a DHCS Certified Provider Site.

    b) The Alliance must develop a process for issuing the Certificate of Completion and coordinate with the county collaborative in the issuance and revocation of certificates for shared provider sites.

    c) If a site's certification is revoked as a result of noncompliance with applicable requirements, the site is no longer deemed a DHCS Certified Provider Site and will not be allowed assignment of members as a PCP until the PCP site has successfully completed the FSR/MRR and closed all CAPs.

    d) The Certificate of Completion does not replace the information form the site review results and outcomes that are shared based on agreed upon processes and methodology.

6. The Alliance must notify its providers in advance for scheduled site reviews. However, inspection of an Alliance's provider facilities or other elements of a review may be conducted without prior notice, in conjunction with other medical surveys or as part of an unannounced inspection program.

7. The Alliance collaborates with other MCPs in geographic areas where shared providers are identified in accordance with DHCS requirements. The Alliance may choose to delegate site review responsibilities to another MCP and accept a collaborating MCP's site review findings. The Alliance retains ultimate responsibility for the assigned sites and oversight of site review completion, results, any necessary CAP, and monitoring of assigned PCP sites ~~per county collaboration.~~.

8. The Alliance requires that Urgent care facilities undergo an initial and subsequent periodic full scope FSR, using the Alliance tool, to participate in Medi-Cal managed care. All urgent care facilities must pass an initial FSR, as part of the credentialing process and a subsequent FSR every three (3) years thereafter, beginning no later than three years after the initial FSR. The purpose of these subsequent FSRs is to evaluate the continuing capacity of the site in supporting the delivery of quality health care services.

9. Physical Accessibility Review Surveys (PARS) (FSR Attachment C, D and E) will be conducted for all PCP sites, Specialist sites, Ancillary Services sites, and Community-Based Adult Services (CBAS) provider sites which provide care to a high volume of seniors and persons with disabilities (SPDs).

10. Delegation of the FSR and MRR processes require a mutually agreed upon contract language in which delegated functions are identified. The Alliance shall oversee and monitor all delegated activities. Through monitoring, the Alliance ensures that the delegated FSR and/or MRR functions are properly carried out. Delegation oversight activities are described in the Alliance policy QI-111 Delegation Management and Oversight.

11. The Alliance will submit aggregated site review data to DHCS every six (6) months as required by APL 22-017.

12. The Alliance ensures that relevant provider-specific information is shared interdepartmentally.

13. The Alliance complies with the Department of Managed Health Care's (DMHC) requirements referenced in Title 28, CCR, Section, 1300.67.1(c) related to medical records for its Medi-Cal and Group Care lines of business.

14. The Alliance ensures its physicians have a process in place to follow up on missed or canceled appointments. The Alliance monitors missed, canceled, and rescheduled appointments through periodic full-scope, focused, and interim monitoring FSR/MRR evaluations.

15. During public health emergencies, the Alliance shall:

    a) Follow local, state, and federal guidelines and requirements to respond to concerns resulting from public health emergencies, such as a pandemic

    b) Follow emergency Executive Orders or APLs that may temporarily change existing FSR policies

    c) Develop standardized protocols for conducting alternatives to in-person site reviews (i.e. video "walk-through", interviews, return demonstration, collection of documentation, desktop review)

16. The Alliance is responsible for ensuring that subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. ~~—~~These requirements are communicated to subcontractors and network providers.

PROCEDURE

1 Initial Site Review and Medical Record Review

1.1 An initial site review consists of an initial FSR, an initial MRR, and PARS.
- 1.1.1 The initial FSR and the initial MRR might not occur on the same date.
- 1.1.2 The FSR is conducted first to ensure the PCP site operates in compliance with all applicable local, state, and federal laws and regulations.

1.2 The Alliance must not add PCPs to the network or assign members to providers until the PCP sites receive a passing FSR score and completes all CAPs.

1.3 An initial FSR is not required when a new provider joins a PCP site that has a current passing FSR score. In situations of provider credentialing or recredentialing, a site survey does not need to be repeated if the site to which the provider is being added has a current passing site review survey score from a prior Alliance-conducted assessment, or from a local MCP with which the Alliance collaborates.

1.4 A DHCS Site Identification Number ("DHCS Site ID") is a unique identifier and must be assigned by the Alliance to each PCP site reviewed.
- 1.4.1 In the event of an ownership change at an established PCP site, a new DHCS Site ID will be assigned. The new DHCS Site ID may be existing Site ID but with a modifier to represent a change of ownership at the site.
- 1.4.2 Local county ~~MPCs~~ MCPs collaborate to manage and assign the DHCS Site ID numbers specific to the county.

1.5 Once a PCP site passes the initial FSR and completes all CAPs, if applicable, the Alliance may add the site's PCP(s) to the network and can begin assigning members to the PCPs at that site.

1.6 An MRR survey is performed at the time of the FSR if Medi-Cal patient records are available; otherwise, the Alliance must complete the initial MRR of the new PCP site within 90 calendar days of the date that Alliance first assigns members.
- 1.6.1 The Alliance may defer this initial MRR for an additional 90 calendar days only if the new PCP(s) does not have enough assigned members to complete the MRR on the required minimum number of medical records. See Shared Medical Records Practice below for details regarding the required minimum number of medical records.
- 1.6.2 If, after 180 days following member assignment, the PCP still has fewer than the required number of patient records, the Alliance must complete the MRR on the total number of medical records it has available, and adjust scoring accordingly to the number of medical records reviewed.

1.7 The Alliance may choose to conduct the MRR portion of the site review on-site or virtually. The virtual process must comply with all applicable Health Insurance Portability and Accountability Act (HIPAA) standards at all times.

2 Additional Scenarios Requiring Initial Reviews. Examples of these scenarios include, but are not limited to the following:

2.1 A new PCP site is added to the Alliance network.

2.2 A newly contracted provider joins/assumes a PCP site with a previous failing FSR and/or MRR score within the last three years.

2.3 A PCP is returning to the Medi-Cal managed care program and has not had passing FSR in the last three years.

2.4 At the discretion of the Alliance, a separate site review may be conducted for solo practices/organizations.

2.5 Upon identification of multiple independent practices that occupy the same site, a separate site review must be completed for all PCP practices at that site and a unique alphanumeric DHCS Site ID must be assigned for each independent PCP practice at the site if ownership is different.

~~2.5.1 Local county collaborative has a process in conducting separate site reviews for shared sites.~~

2.6 A change of ownership of an existing provider site is planned and/or identified.

2.7 When a PCP site relocates, the following must occur:

2.7.1 The relocating PCP site is required to undergo an initial site review process.

2.7.2 The Alliance must allow established members to continue to see the provider at the new location, but not assign new members until the initial site review is completed.

2.7.3 The relocated PCP site must pass the initial FSR score within 60 days of notification or discovery of the completed move.

2.7.4 Upon passing the initial FSR and closing CAPs, if applicable, the following will occur:

2.7.4.1 The PCP site may be formally added to the network.

2.7.4.2 New and established relocating members can be formally assigned to the new provider location.

2.7.5 If the relocated PCP site does not pass the initial FSR within two attempts, or does not complete the required CAPs per established timelines, the following will occur:

2.7.5.1 The relocated PCP site may not be added to the Alliance provider network.

2.7.5.2 The previous PCP site must be removed from the network, if the site has closed.

2.7.5.3 Current assigned membership must be reassigned to another network PCP, if the previous site has closed.

2.7.5.4 The relocated PCP site may reapply six (6) months from the last FSR survey.

2.8 Pre-operational FSRs will be completed prior to operations in a new service area or expansion on a specified number of PCP sites in accordance with contract specifications and APL 22-017. The FSR portion of the initial site review must be completed prior to start of new or expanding Alliance operations.

3 **Supplemental Facilities** (Mobile, Satellite, School Based, and Other Extension Clinics) assist in the care delivery of primary care services to geographically remote areas that lack health care services, as well as assist the underserved population in areas where there may be access to care concerns.

3.1 Supplemental facilities may offer a variety of clinical services including, but not limited to: preventive care, immunizations, screenings, and/or chronic care management (excluding specialty services).

3.2 Mobile clinics are self-contained units including vans, recreational vehicles, and other vehicles that have been repurposed to provide space for various clinic services, and may also serve to deliver equipment to locations that operate temporary clinics.

3.3 In general, supplemental facilities that provide primary care services may serve as an extension of a PCP site, a community-based clinic, a Federally Qualified Health Center county facility, or a stand-alone clinic with members assigned.

3.4 The Alliance must conduct an initial site review and subsequent site reviews of supplemental facilities at least every three years thereafter, with a focus on areas relevant to the services being provided by the supplemental facilities.

3.5 The Alliance must establish a process to complete the oversight of supplemental facilities and collaborate with MCPs within the county.

3.6 Street medicine providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review.

3.6.1 For street medicine providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, the Alliance must conduct the full review process of the street medicine provider and affiliated facility in accordance with APL 22-017.

3.6.2 For street medicine providers serving as an assigned PCP, and that are <u>not</u> affiliated with a brick-and-mortar facility or mobile unit/RV, the Alliance must conduct a condensed FSR and MRR of the street medicine provider to ensure member safety.

4 Requirements for Subsequent Site Reviews

4.1 The Alliance is required to conduct subsequent site reviews, consisting of an FSR, MRR, and PARS, at least every three (3) years.

4.2 The subsequent site visit would be conducted no later than three (3) years after the initial FSR, and at least every three (3) years thereafter.

4.3 The Alliance may conduct site reviews more frequently when determined necessary based on monitoring, evaluation, or CAP follow-up issues.

5 Scoring Requirements

5.1 The Alliance must base FSR and MRR scores on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel.

5.2 If a site reviewer chooses to review additional criteria not included on the FSR or MRR tools, the site reviewer must not include the additional criteria in the existing scoring method.

5.3 The Alliance must not alter the scored criteria or assigned weights in any way.

5.4 The FSR tool is composed of both critical and non-critical elements.

5.4.1 Critical elements (CE) are indicated by bold and underlined text. CEs have the largest potential for adverse effects on patient health or safety and therefore have a scored weight of two (2) points.

5.4.2 Non-critical review elements have a scored weight of one (1) point.

5.5 All MRR tool review elements have a scored weight of one (1) point each.

5.6 The MRR score is based on a standard review of ten randomly selected member medical records, consisting of pediatric, adult, or obstetric medical records, according to the member population served.

5.6.1 For PCP sites serving only pediatric or only adult patients, all ten medical records must be reviewed using the appropriate preventive care criteria.

5.6.2 Pediatric preventive services are provided to members under 21 years of age in accordance with current American Academy of Pediatrics (AAP) Bright Future recommendations.

5.6.3 For adults age 21 years and older, preventive services are provided in accordance with United States Preventive Services Task Force (USPSTF) A and B recommendations.

5.6.4 For obstetricians and gynecologists acting as PCPs and PCPs providing obstetric care in accordance with American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) standards, all medical records must be reviewed using preventive care criteria for adults or pediatrics (pregnant members under age 21 years) and obstetrics.

6 Shared Medical Records Practice

6.1 A shared medical record practice occurs when multiple PCPs see the same patients and use the same medical records for documentation of patient care.

6.2 If a PCP site documents patient care performed by multiple PCPs in the same medical record, the Alliance must consider these medical records a shared medical record system.

6.3 The Alliance must consider shared medical records as those that are not identifiable as separate records belonging to any specific PCP.

6.4 The Alliance must review the number of medical records according to the number of PCPs and population served in that shared medical record system, per the table below:

Number of PCPs	Minimum number of medical records (based on the general patient population distribution: pediatrics, adult, obstetrics)
1-3	10
4-6	20
7+	30

6.5 If a minimum number of records are not available for review due to limited patient population, the reviewer will complete the MRR, document the rationale, and adjust the score as needed.

6.6 In the event that there are multiple providers in one office that do not share medical records, each PCP must be reviewed separately and receive a separate score. A minimum of ten medical records must be reviewed per provider.

6.7 During the MRR, site reviewers have the options to request additional medical records for review to ensure adequate review of all provider specialties, member populations, etc.

If the site reviewer chooses to review additional medical records, the scores must be calculated accordingly.

6.8 The Alliance may choose to conduct the MRR portion of the site review onsite or virtually.

6.8.1 The virtual process must comply with all applicable HIPAA standards at all times, regardless of the chosen method.

6.9 Both onsite and virtual MRRs may include the review of medical records for members belonging to another MCP, and may include the viewing, collection, storage, and transmission of Protected Health Information (PHI).

6.10 Scores are issued based on established scoring procedures, located in the FSR and MRR review tools.

6.11 PCP sites will achieve a separate score for the FSR and/or MRR as described in the table below:

	Exempted Pass	**Conditional Pass**	**Fail**
FSR	• Score of 90% and above with **no** deficiencies in CEs, Infection Control or Pharmacy **CAP NOT Required**	• Score of 90% and above **with** deficiencies in CEs, Infection Control, or Pharmacy • Score of 80-89%, regardless of deficiencies **CAP required**	• Score of 79% or below **CAP required**
MRR	• Score of 90% and above, with all section scores at 80% and above **CAP NOT Required**	• Score of 90% and above with one or more section below 80% • Score of 80-89%, **CAP required**	• Score of 79% or below **CAP required**
The Alliance may require a CAP regardless of score for other findings identified during the survey that require correction.			

6.12 For detailed scoring procedures, see the FSR and MRR tools and standards.

7 Failing Scores

7.1 If a PCP site receives a failing score from one MCP, all other MCPs must consider the PCP site as having a failing score.

7.2 The Alliance must use the county collaborative process to identify shared providers and determine methods for sharing site review information, including CAPs, failed sites, and provider termination.

7.3 When a PCP site receives a failing score on an FSR or MRR, the Alliance must notify the PCP site of the score, all cited deficiencies, and all CAP requirements.

7.4 The Alliance may choose to remove any PCP site with a failing FSR or MRR score from the network.

7.4.1 If the Alliance allows a PCP site with a failing FSR or MRR score to remain in the network, the Alliance must require and verify that the PCP site has corrected the identified deficiencies within the CAP timelines established in this policy.

7.5 The Alliance must not assign new members to network PCP sites that receive a failing score on an FSR or MRR until the Alliance has verified that the PCP site has corrected the deficiencies and the CAP is closed.

7.6 Based upon mutual agreement between the Alliance and the provider site, additional training and technical assistance may be available when a PCP site fails an initial FSR prior to contracting with the Alliance.

7.6.1 Pre-contracted providers who do not pass the initial FSR may use the first attempt as a learning and technical assistance opportunity.

7.6.2 If the provider fails the site review after the second attempt, the provider will need to reapply to the Alliance after six (6) months from the date of the second attempt.

7.7 PCP sites that receive a failing score on either the FSR or MRR for two (2) consecutive site reviews must receive a minimum passing score, i.e. Exempted Pass or Conditional Pass on the next FSR and MRR (including PCPs with open CAPs in place) to remain in the Alliance provider network.

7.8 If the PCP site fails on its third consecutive attempt, despite the Alliance's ongoing monitoring and assistance, the PCP site will not have an opportunity to complete a CAP, and must be removed from the Alliance's provider network.

7.8.1 Impacted members must be reassigned to other network providers, as appropriate and as contractually required.

7.8.2 If a PCP site is removed from one MCP network due to three consecutive failing scores, all other MCPs must also remove the PCP site from their networks.

8 Corrective Action Plan

8.1 A CAP is required for all cited deficiencies for PCP sites that have an FSR and/or MRR conditional pass or non-passing score.

8.2 The Alliance may require a CAP for other findings identified during the survey that require correction, regardless of the score.

8.3 There is no rescoring of the FSR or MRR as deficiencies are corrected or addressed, and points are still deducted even if deficiencies are corrected at the time of the audit.

8.4 CAPs are also required when there are CE, pharmacy, and infection control deficiencies found during any site review activity, including but not limited to, focused reviews, monitoring activities, or other reviews done by the Alliance or DHCS.

8.5 The Alliance must not assign new members to providers who fail to correct site review deficiencies within the established CAP timelines.

8.6 For providers that fail to comply with their CAP, the Alliance must verify that the PCP site has corrected the deficiencies and the CAP is closed before assigning new members.

8.7 Ultimately, the Alliance must remove any provider from the network that does not come into compliance with review criteria and CAP requirements with the established timelines.

8.7.1 Alliance must expeditiously reassign that provider's members to other network providers. Information regarding provider terminations is described in Alliance policy PRV-005 Provider Terminations.

8.8 The Alliance must follow the established timeline below for CAP notification and completion:

CAP Timeline	**CAP Action(s)**
Day of the FSR and/or MRR	The Alliance must provide the PCP site with the following: • Verbal notification of any CE finding(s) and a signed attestation by the PCP/Site Designee and the Alliance staff confirming that a discussion regarding CE findings occurred. (This serves as the start of the CE CAP timeline). • A formal written request for CAPs to address all CEs, if applicable, the day of the site visit but no later than one (1) business day after the site visit completion. • The FSR score the day of the site visit but no later than one (1) business day after the FSR completion. • The MRR score the day of the site visit but not later than one (1) business day after MRR completion.
Within 10 business days from the date of completing the FSR visit and/or MRR	• The PCP site must submit a CAP and evidence of correction(s) to the Alliance for all deficient CE(s), if applicable. • The Alliance must review, approve, or request additional information on the submitted CAP(s) for CE findings. • The Alliance must provide a report to the PCP site containing FSR and/or MRR findings, along with a formal written CAP request for CAPs for all non-CE deficiencies. (This serves as the start of the non-CE CAP timeline). • The Alliance must provide educational support and technical assistance to the PCP sites, as needed.
Within 30 calendar days from the date of the completed FSR	• The Alliance must verify that all aspects of CE CAPs are completed. • Providers can request a definitive, time-specific extension to correct CE deficiencies, to be granted at the discretion of the Alliance, not to exceed 60 calendar days from the date of the FSR.

Within 30 calendar days from the date of the FSR and/or MRR Report	• The PCP site must submit a CAP for all non-CE (FSR/MRR) deficiencies to the Alliance. • The Alliance must provide educational support and technical assistance to PCP sites, as needed.
Within 60 calendar days from the date of the FSR	• For those sites that were granted an extension for the CE CAPs, the Alliance must verify that all CE CAPs are closed.
Within 60 calendar days from the date of the FSR and/or MRR Report	• The Alliance must verify that non-critical CAPs are completed. • The Alliance must review, approve, or request additional information on the submitted CAP(s) for non-critical findings. • The Alliance must continue to provide educational support and technical assistance to PCP sites, as needed.
Within 90 calendar days from the date of the FSR and/or MRR Report	• All non-critical CAPs must be closed. • Providers can request a definitive, time-specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of the FSR and/or MRR findings.
Beyond 120 calendar days from the date of the FSR and/or MRR Report	• Under extenuating circumstances*, the Alliance can request from DHCS a definitive, time-specific extension period to allow for 1) the PCP site to complete the CAP and/or 2) the Alliance to verify CAPs have been completed. • The Alliance must conduct a focused FSR and/or MRR, as applicable, within 12 months of the original FSR and/or MRR date(s). * Examples of extenuating circumstances may include, but are not limited to, fire, flood, natural catastrophes, virus epidemic/pandemic, etc. (provider staff on vacation is not considered an extenuating circumstance).

8.9 The Alliance is responsible for providing the site with the CAP requirements, including the CAP template and appropriate documentation as listed below:
- 8.9.1 The specific deficiency;
- 8.9.2 Corrective actions needed;
- 8.9.3 CAP due dates;
- 8.9.4 Instructions for CAP submission; and
- 8.9.5 The Alliance contact information

8.10 The Alliance is responsible for conducting follow-up, verification, and closure of CE, FSR, and MRR CAPs to ensure that the site has implemented a process and/or procedures to make corrections as noted on the CAP.

8.11 All CAP (CE, FSR, MRR) verifications may be done via review of document submission via fax or email, virtual platform, or an onsite review, per nurse reviewer discretion and/or Alliance policy and procedure.

8.12 DHCS reserves the right to require the Alliance to conduct CAP verification onsite.

8.13 Closed CAP documentation must include:
- 8.13.1 Documentation of problems in completing corrective actions (if any);
- 8.13.2 Resources and technical assistance provided by the Alliance;
- 8.13.3 Evidence of the corrections;
- 8.13.4 Completion and closure dates; and
- 8.13.5 Name and title of the Alliance reviewer.

8.14 The Alliance follows an escalation process for providers who are non-responsive to CAPs for FSR/MRR and for CEs.

9 Monitoring

9.1 The Alliance must monitor all PCP sites between each regularly scheduled full scope site review

9.2 Monitoring methods may include, but not limited to:
- 9.2.1 Site reviews;
- 9.2.2 Follow-up verification of corrective action implementation;
- 9.2.3 Interim Monitoring (IM) Attestation form;
- 9.2.4 Information gathered through internal quality management systems such as grievance data, Potential Quality Issue (PQI) referrals, Healthcare Effectiveness Data and Information Set (HEDIS®) data, and focused review, when necessary;
- 9.2.5 Provider and program-specific reports from external sources of information (e.g. public health).

9.3 At a minimum, the Alliance must monitor and evaluate all CEs for all PCP sites between scheduled site reviews.

9.4 When the Alliance identifies deficiencies through monitoring, it must determine the appropriate course of action, such as conducting a site review or additional focused reviews, to educate and correct the deficiencies according to established CAP timelines.

10 Focused Review

10.1 A focused review is a targeted review of one or more specific areas of the FSR or MRR.

10.2 The Alliance must not substitute a focused review for a site review.

10.3 The Alliance may use focused reviews to monitor provider between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions.

10.4 Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review, or other methods to investigate identified deficiencies or situations.

10.5 At the reviewer's discretion, a CAP may be given during a focused review.
- 10.5.1 All deficiencies identified in a focused review requiring a CAP must require the completion and verification of corrective actions according to CAP timelines established in this policy.

11 County Collaboration

11.1 The Alliance must collaborate locally within each Medi-Cal managed care county to establish systems and implement procedures for the coordination, consolidation, and data sharing of site reviews for mutually contracted PCPs.

~~11.1.1 This may include reviewing medical records of a member belonging to another MCP, including the viewing, collection, storage and transmission of PHI.~~

~~11.2 All MCPs within a county have equal responsibility and accountability for participation in the site review collaborative processes.~~

~~11.3 The MCPs must submit an initial written description and periodic update reports as requested and instructed by DHCS describing the county collaboration processes, which must include, but are not limited to, the following:~~

~~11.3.1 Names and titles of each MCP's participating personnel.~~
~~11.3.2 A work plan that includes goals, objectives, activities, and timelines.~~
~~11.3.3 Scheduled meeting dates, times, and locations.~~
~~11.3.4 Meeting processes and outcomes.~~
~~11.3.5 Communication and information sharing processes.~~
~~11.3.6 Roles and responsibilities of each MCP.~~
~~11.3.7 Delegated activities and use of delegated or sub-delegated entities.~~
~~11.3.8 Memorandum of Agreement (MOA) requirements established for collaborating MCPs.~~

~~11.4 The Alliance and MCPs must establish policies and procedures to define local collaborative methodology for the following:~~

~~11.4.1 Identification of shared providers.~~
~~11.4.2 Confidentiality, disclosure, and release of shared provider review information and site review results.~~
~~11.4.3 Site review processes.~~
~~11.4.4 Issuance of Certificate of Completion.~~
~~11.4.5 Oversight and monitoring of review processes.~~
~~11.4.6 Site review personnel and training processes.~~
~~11.4.7 Collection and storage of site review results, including PHI.~~

~~11.5 To avoid duplication of efforts and disruption to PCPs practicing at the same site, the Alliance may include a non-contracted PCP(s) in the site review, at the agreement of the collaborating MCPs.~~
~~11.5.1 At the discretion of the collaborating MCPs, site review scores and outcomes may be shared and accepted.~~
~~11.5.2 In the event site review scores are not accepted by other MCPs, a site review must be performed.~~

~~11.6~~11.2 In instances where contracted PCP sites are located in a bordering county, the MCPs may share site activity information such as scores, CAP completion, and/or noncompliance, with bordering county MCPs to avoid duplicative site reviews.

~~11.7~~11.3 Formal agreements must be in place in order to disclose PHI, such as the review of medical records of a member belonging to another MCP.

11.4 The Memorandum o~~O~~f Agreement for MCP collaboration includes the following procedures, but are not limited to:

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~~11.7.1~~11.4.1 The Alliance agrees to accept other MCP's surveys of PCP sites if completed using approved DHCS survey tools and performed by DHCS CSR or CMT.

~~11.7.2~~11.4.2 If a PCP site receives a failing score from one MCP, Alliance must consider the PCP site as having a failing score. MCPs will notify other MCPs within three (3) business days of any shared facility failing below 80% via fax or electronic form.

11.4.3 Notification of the other MCP(s) within 3 business days if PCP sites are non-compliant with CAP timeline.

~~11.7.3~~ MCPs must not assign new members to providers with failing scores and/or providers who do not correct site review deficiencies within the established CAP timelines. MCPs must verify that the PCP site has corrected the deficiencies and the CAP is closed. MCPs must remove any providers from the network who does not come into compliance with review criteria and CAP requirements within the established timelines, and the MCPs must appropriately reassign that provider's MCP members to other network providers.

~~11.8~~11.4.4

11.8.1.1 MCPs must not assign new members to providers with failing scores and/or providers who do not correct site review deficiencies within the established CAP timelines. MCPs must verify that the PCP site has corrected the deficiencies and the CAP is closed. MCPs must remove any providers from the network who does not come into compliance with review criteria and CAP requirements within the established timelines, and the MCPs must appropriately reassign that provider's MCP members to other network providers.

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~~11.8.1.3 Notification of the other MCP(s) within 3 business days if PCP sites are non-compliant with CAP timeline.~~

~~11.8.1.4~~11.8.1.1 ~~MCPs must not assign new members to providers with failing scores and/or providers who do not correct site review deficiencies within the established CAP timelines. MCPs must verify that the PCP site has corrected the deficiencies and the CAP is closed. MCPs must remove any providers from the network who does not come into compliance with review criteria and CAP requirements within the established timelines, and the MCPs must appropriately reassign that provider's MCP members to other network providers.~~

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12 Site Reviewer Personnel

12.1 The Alliance must designate a minimum of one (1) physician, nurse practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) to be certified by DHCS as the Alliance's CMT.

12.2 The CMT has the overall responsibility for the training, supervision, and certification of site reviewers, as well as the monitoring of site reviews and evaluating of site reviewers for accuracy.

12.3 A designated CMT/CSR is responsible for and must sign the FSR and MRR tools. Only physicians, NPs, PAs, or RNs are eligible to become CSRs.

12.4 A variety of personnel can also be part of the site review team, including pharmacists, dieticians, coordinators, and others to provide assistance and clarification.

12.5 An RN is the minimal level of site reviewer acceptable for independently performing site reviews. RN reviewers can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings to initiate peer review procedures. An RN can only delegate site review tasks to a subordinate based on the subordinate's legal scope of practice and on the degree of preparation and ability required by the site review tasks that the RN would delegate.

12.6 The Alliance maintains written policies and procedures that clearly define the duties and responsibilities of all site review personnel.

12.7 The Alliance must demonstrate that site review activities established for its reviewers comply with the site reviewers' scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the site reviewers' level of education and training.

13 Site Review Training and Certification

13.1 Physicians, NPS, PAs, and/or RNs that are designated by the Alliance to be CMTs or CSRs must meet the certification and recertification requirements outlined in the respective table below to be certified as a CMT or CSR.

13.2 CMT candidates must apply for certification directly to DHCS using Attachment A of APL 22-017, Application for DHCS Site Review Master Trainer Certification.
- 13.2.1 Applications must be submitted to the Alliance's assigned Nurse Evaluator. Upon certification and recertification, CMTs will receive a certificate signed by DHCS.
- 13.2.2 CMTs must be recertified every three (3) years.
- 13.2.3 CMT certification is transferable across participating MCPs.
- 13.2.4 The Alliance may confirm certification status by contacting DHCS.

13.3 The Alliance is responsible for ensuring that all site reviewers are appropriately trained, evaluated, certified, and monitored.

13.4 The Alliance may collaborate with the other MCPs to determine local systems for training and certifying site reviewers.
- 13.4.1 Training must include DHCS seminars, MCP classes, individual or small group training sessions provided by a CMT, and self-study learning programs.

13.5 The Alliance can only certify physicians, NPs, PAs, or RNs as CSRs.
- 13.5.1 Upon certification, CSRs will receive written verification of certification by the Alliance
- 13.5.2 CSRs must be recertified every three (3) years.
- 13.5.3 CSR certification is transferrable across participating MCPs.
- 13.5.4 The Alliance may confirm certification status by contacting DHCS.

14 Inter-rater Review Process

14.1 Candidates for CMT and CSR certifications must complete an inter-rater review (IRR) process as part of both the initial certification and recertification processes.
- 14.1.1 The inter-rater for CMT candidates is a DHCS Nurse Evaluator. The IRR process requires the CMT candidate to concurrently complete and score a site review with

the DHCS Nurse Evaluator utilizing the DHCS FSR and MRR tools and standards.

14.1.2 The inter-rater for CSR candidates is the Alliance's CMT. The IRR process requires the CSR candidate to participate with the Alliance's CMT to concurrently complete and score a site review utilizing the DHCS FSR and MRR tools and standards.

14.1.3 The CMT or CSR candidate must achieve the required inter-rater score as described in the tables below in order to be certified.

14.2 If the CMT or CSR candidate does not meet the appropriate inter-rater score variance, they may repeat the process one (1) time.

14.2.1 The appropriate inter-rater (DHCS Nurse Evaluator or Alliance's CMT) and the candidate with the failing inter-rater score will jointly assess training needs and implement a training plan prior to conducting the second IRR.

14.2.2 CMT and CSR candidates that do not meet the appropriate inter-rater variance score for the second IRR must wait six (6) months to reapply for certification.

14.3 The Alliance must develop policies and procedures for certification, ongoing supervision and monitoring of site review personnel to ensure reliability of site review findings and data submitted to DHCS.

14.4 The Alliance must maintain certification records including, but not limited to, site review training activities and supporting documentations to support the certification requirements.

Initial Certification Requirements	**CMT**	**CSR**
Possess a current and valid California RN, Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP, or PA license.	X	X
Be employed by or subcontracted with an MCP.	X	X
Submit Attachment A, Application for DHCS Site Review Master Trainer Certification.	X	
Have experience in conducting training in a health related field, or conducting quality improvement activities such as medical audits, site reviews, or utilization management activities within the past three (3) years.	X	
Complete twenty (20) FSRs and twenty (20) MRRs, and one (1) year of experience as a CSR.	X	
Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.	X	
Attend didactic site review training or completion of DHCS site review training modules on the current site review tools under supervision of a CMT.		X
Complete ten (10) FSRs and ten (10) MRRs with a CSR or CMT.		X
Achieve an inter-rater score within 10% in FSR and 10% in MRR with designated CMT.		X

Recertification Requirements	CMT	CSR
Possess a current and valid California RN, MD, DO, NP, or PA license.	X	X
Be employed by or subcontracted with an MCP.	X	X
Be responsible for staff training on the most current DHCS site review tools and standards.	X	
Participate in DHCS-sponsored site review trainings as well as Site Review Work Group (SRWG) meetings and teleconferences.	X	
Maintain CMT certification.	X	
Complete a minimum of thirty (30) site reviews following initial certification or recertification.	X	X
Attend DHCS-sponsored inter-rater workshops in person or virtually every three (3) years.	X	X
Achieve within a 5% variance on the MRR, on the statewide inter-rater score as defined by the SRWG and DHCS.	X	
Achieve within a 10% variance on the MRR, on the statewide inter-rater score as defined by the SRWG and DHCS.		X

15 Data Submission Procedures

15.1 The Alliance is required to submit site review data to DHCS every six (6) months (July 31 for the period January – June, and January 31 for the period July – December) in an approved format uploaded to a designated DHCS secure site.

15.2 The Alliance is permitted to submit data more frequently than every six (6) months.

15.3 For preoperational and expansion site reviews, the Alliance must submit site review data to DHCS at least six (6) weeks prior to site operation.

15.4 DHCS will make available the database containing all necessary tables and data input forms for the mandatory bi-annual submission of site review data.
15.4.1 DCHS will reject site review data submitted in non-conforming formats.

15.5 The Alliance is required to collect PHI as part of the MRR process, and must include the PHI in the bi-annual data submission to DHCS.

16 DHCS-Conducted Site Reviews

16.1 DHCS conducts separate site reviews to validate the Alliance's FSR and MRR processes.

16.2 Prior to a new MCP's operation, or an MCP expansion to a new county, DHCS conducts initial FSRs followed by initial MRRs of randomly chosen PCP sites in the MCP's network upon MCP beginning operations and assignment of members, as outlined in DHCS APL 22-017.

16.3 DHCS also conducts subsequent site reviews on PCP sites within the Alliance's networks.

16.4 DHCS will notify the Alliance of critical findings in writing via email within 10 business days following the date of the FSR and/or MRR and provide a written report summarizing all of DHCS' review findings within 30 calendar days following the date of the FSR and/or MRR.

16.5 Within 30 calendar days from the date of the Alliance's receipt of the DHCS-conducted site review report, the Alliance must provide a CAP to DHCS responding to all cited deficiencies documented in the report. The Alliance's CAP response must include:
16.5.1 The identified deficiency (ies).
16.5.2 A description of action(s) taken to correct the deficiency (ies).

16.6 If a deficiency is determined to require long-term corrective action, the Alliance's CAP response must include indication that the Alliance has:
16.6.1 Initiated remedial action(s).
16.6.2 Developed a plan to achieve an acceptable level of compliance.

16.6.3 Documented the date the provider is in full compliance or when full compliance will be achieved.

16.7 Additional supporting documentation and remedial action may be required if DHCS determines CAPs are insufficient to correct deficiencies.

16.8 The Alliance will be notified approximately four (4) weeks in advance of DHCS-conducted site reviews.

16.9 The Alliance must notify its providers in advance of site reviews, whether the site review is conducted by DHCS or by the Alliance.

16.10 Inspection of the Alliance's facilities or other elements of a review may be conducted without prior notice, in conjunction with other medical surveys or as part of an unannounced inspection program.

17 Physical Accessibility Review Survey

17.1 Physical Accessibility Review Surveys (PARS) (FSR Attachment C, D and E) will be conducted for all PCP sites, Specialist sites, Ancillary Services sites, and Community-Based Adult Services (CBAS) provider sites which provide care to a high volume of seniors and persons with disabilities (SPDs).

17.2 The PARS include elements to ensure access for people with disabilities, including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

17.3 By January 31 of each year, the Alliance will notify DHCS with any changes made to the method used for identifying high-volume Specialists and Ancillary Services providers. If no changes have been made, a letter stating this must be submitted to DHCS.

17.4 As hospitals represent a unique group of ancillary providers, the Alliance is required to collaborate with its network hospitals to assess whether they meet all of the elements in Attachment C and make this information available through the Alliance's website and provider directories. The Alliance must demonstrate it has received adequate documentation from hospitals to complete Attachment C and maintain records that support assessment of each network hospital.

17.5 The Alliance may update the high-volume benchmarks based on availability of more complete utilization data.

17.5.1 Any revision of benchmarks used to identify high-volume providers will include a description of the methodology used to revise those benchmarks, and utilization or other data in support of the revision.

17.6 Results of PARS (FSR Attachment C, D & E) are informational and, unlike the FSR and MRR, do not require corrective action. However, the Alliance is required to maintain all

original documentation of FSR assessments and make this information available to DHCS for contract monitoring or auditing purposes.

17.7 PARS are performed by an FSR Coordinator, a CSR, or a CMT utilizing state-mandated audit tools. FSR Attachment C is utilized for PCP and Specialist sites, FSR Attachment D is utilized for Ancillary Services sites, and FSR Attachment E is utilized for CBAS provider sites.

17.8 Data obtained from FSR Attachment C will be used to determine and identify physical accessibility indicators that will be made available to members through the Alliance's provider directory and on the Alliance's member website.

17.8.1 The information provided must, at a minimum, display the level of access results met per provider site as either Basic Access or Limited Access. Additionally, the Alliance must indicate whether the site has Medical Equipment Access, as defined in FSR Attachment C, and identify whether each provider site has access in the following categories: parking, building exterior, building interior, exam room, restroom, and medical equipment (height adjustable exam table and patient accessible weight scales).

17.8.2 Definitions for each physical accessibility indicator will be included in the instruction section of the provider directory and Alliance website.

18 Reviewing medical records and medical records systems

18.1 The Alliance complies with DMHC's requirements relating to medical records, per Title 28, CCR, Section 1300.80(b). These requirements include:

Ensuring the provider provides maintenance and ready availability of medical records and shares with the health plan all pertinent information relating to the health care of each member.

18.2 Reviewing medical records during which assessment of the following is documented:

18.2.1 Entries establish the diagnosis stated, including an appropriate history and physical findings

18.2.2 Notes of therapies reflect an awareness of current therapies

18.2.3 Important diagnoses are summarized or highlighted (especially those conditions that have a bearing on future clinical management)

18.2.4 Drug allergies and idiosyncratic medical problems are noted

18.2.5 Pathology, laboratory, and other reports are recorded

18.2.6 The health professional responsible for each entry is identifiable

18.2.7 Any necessary consultation and progress notes are evidenced as indicated

18.2.8 An appropriate system is maintained for coordination and availability of the medical records of the member, including outpatient, inpatient, and referral services and significant telephone consultations

18.2.9 Appropriate follow-up care based on assessment such as, but not limited to, additional assessments or specialist referrals (i.e., depression screenings, annual cognitive health assessments, etc.).

18.2.10 Appropriate consents such as, but not limited to, treatments, medical procedures, telehealth services, etc.

18.3 Establishing medical record documentation standards that are shared with the Alliance's provider network.

18.4 Creating an effective medical record audit tool that addresses continuity of care and coordination of care between and among providers.

18.5 Scheduling of regular medical record audits and corrective action procedures for addressing identified deficiencies including complete follow-up review.

19 All Plan Letter and Policy Letter updates

19.1 The Alliance is responsible for ensuring that subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements are communicated to subcontractors and network providers.

19.2 If the requirements in the DCHC's APLs or PLs, including any updates or revisions, necessitate a change in the Alliance's contractually required policies and procedures (P&Ps), the Alliance must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of the DHCS APL or PL.

19.3 If the Alliance determines that no changes to its P&Ps are necessary, the Alliance must
19.3.1 Submit an email confirmation to its MCOD contract manager within 90 days of the release of the DHCS's APLs or PLs stating that the Alliance's P&Ps have been reviewed and no changes are necessary.
19.3.2 The email confirmation must include the title of the APL or PL as well as the applicable APL or PL release date in the subject line.

DEFINITIONS

Ancillary Services – For the purpose of this policy, ancillary services refer to facilities that provide diagnostic and therapeutic services such as but not limited to, radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations.

Certified Master Trainer (CMT) – A physician, nurse practitioner (NP), physician assistant (PA), or registered nurse (RN) certified by DHCS that is responsible for providing the training, supervision, and certification of the CSRs, as well as the monitoring of site reviews and evaluating of site reviews for accuracy. DHCS collaborates with the Alliance to develop, implement, and

evaluate site review training and certification, revise training curriculum and materials as needed, and provide technical assistance to CMTs on an ongoing basis.

Certified Site Reviewer (CSR) – A physician, NP, PA, or RN certified by a CMT to conduct FSRs and MRRs utilizing state-mandated audit tools.

Community-Based Adult Services (CBAS) - An outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutritional services, and transportation to eligible Medi-Cal beneficiaries who meet criteria as defined in the California Bridge to Reform Waiver 11- W-00193/9, Special Terms and conditions, Paragraph 91.

Conditional Pass Score – For FSRs, a score of 80-89 percent, or 90 percent or above with deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control. For MRRs, a score of 80-89 percent, or score of 90% and above with one or more section below 80%.

Corrective Action Plan (CAP) – 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.

Critical Element (CE) – Survey elements within the FSR inspection identified as "critical" due to their potential for adverse effects on patient health or safety. CE has a scored weight of two (2) points on the FSR tool.

Facility Site Review (FSR) and Medical Record Review (MRR) Tools – State-developed and state-mandated instruments used to evaluate provider practices. The tools contain applicable local, state, federal and Alliance requirements and standards.

Focused Review – A targeted audit of one or more specific areas of the FSR or MRR as the result of issues identified through quality monitoring activities. All deficiencies identified in a focused review must require the completion and verification of corrective actions according to established CAP timelines.

Full Scope Site Review – Initial and periodic PCP site inspections performed by a CSR or CMT using state-mandated audit tools.

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

Interim Monitoring (IM) – The monitoring of PCP sites between regularly scheduled site reviews for the purpose of monitoring and evaluating critical elements.

Physical Accessibility Review Survey (PARS) (FSR Attachment C, D & E) – State- developed and state-mandated tool used to assess the level of physical accessibility of provider sites.

Primary Care Provider (PCP) - a participating physician selected by a member or who has been assigned by the Alliance to render first contact medical care and to provide covered primary care services. PCP shall include specialists choosing to act as a PCP for a SPD member.

Seniors and Persons with Disabilities – These are Medi-Cal beneficiaries who fall under specific SPD aid codes as defined by DHCS.

Supplemental Facilities – For the purposes of this policy, supplemental facilities include mobile, satellite, school-based, and other extension clinics. Supplemental facilities assist in the care delivery of primary care services.

AFFECTED DEPARTMENTS/PARTIES

All Departments

RELATED POLICIES AND PROCEDURES

QI-101 Quality Improvement Health Equity Program
QI-104 Potential Quality Issues (PQIs)
QI-107 Appointment Access and Availability Standards
QI-111 Delegation Management and Oversight
QI-114 Monitoring of Access and Availability Standards
QI-115 Access and Availability Committee
QI-124 Initial Health Appointment (IHA)
PRV-005 Provider Terminations
CRE-002 Credentialing and Re-credentialing of Individual Practitioners
CBAS-001 Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Escalation Process for Providers Non-Responsive to FSR/MRR CAPs
Escalation Process for Providers Non-Responsive to Critical Element CAPs

REVISION HISTORY

1/1/08, 10/09, 2/26/10, 4/01/11, 5/01/11, 9/18/12, 11/6/14, 4/13/15, 5/3/18, 3/21/19, 5/21/20, 3/18/21, 03/22/2022, 03/21/2023, 6/20/2023

REFERENCES

DHCS Contract, Exhibit A, Attachment 4-10 and 13
DHCS MMCD All Plan Letters 02-006, 03-006, 15-023, and 22-017
DHCS MMCD Policy Letter 12-006
Title 22, CCR, Sections 53861, 56230
Title 28, CCR, Section 1300.67.1(c), 1300.80(b)
DHCS Contract Exhibit A, Attachment 18
Memorandum of Understanding for Managed Care Health Plans (the Alliance, Anthem Blue Cross, and Contra Costa Health Plan)
Americans with Disabilities Act of 1990 (42 U.S.C. § 1211 et seq.)
Section 504 and 508 of the Rehabilitation Act (29 U.S.C. § 794)
1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116)
SB 223
SB 1423
APL 17-006
Title 28, Code of Federal Regulations (CFR), section 35.151
APL 22-017 Street Medicine
APL 22-025 Responsibilities for Annual Cognitive Health Assessment
APL 23-007 Telehealth Services Policy

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	PH-003
Policy Name	Risk Stratification & Segmentation (RSS) Process
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Population Health and Equity
Line(s) of Business	Medi-Cal, IHSS
Effective Date	9/19/2023
Subcommittee Name	Quality Improvement and Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

1. Alameda Alliance for Health (AAH) is 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): AAH 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 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 AAH 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 PHM Service and RSS Methodology have been implemented, AAH 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 PHM service.
     - 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

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.

1.1.5. AAH considers findings from the Population Needs Assessment (PNA) 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 launch: AAH categorizes eligible members into risk tiers through the following mechanisms:
   1.1. AAH'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. Criteria utilized for Enhanced Case Management (ECM) and Complex Case Management (CCM) identification is also incorporated into the methodology. Additionally, utilization, care management, and eligibility information are included in capturing members who qualify as high risk.
   1.2. AAH 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, AAH 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 AAH 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:

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. AAH claims data from HealthSuite (AAH's claims and eligibility system) 2. Provider submitted encounter data stored in the AAH 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. Data sources are also used to identify members who qualify as high risk based on the PHM Policy Guide.

Data Source	Resourced From	RSS Incorporation
Pharmacy claims and encounters (NCQA PHM 2 Element 2: Pharmacy claims)	1. AAH claims data from HealthSuite 2. Historical pharmacy data extracts from AAH's Pharmacy Benefits Manager 3. Current pharmacy data extracts from DHCS (Service Dates 1/1/2022 forward)	Data sources are used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology.
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. Data sources are also used to identify members who qualify as high risk based on the PHM Policy Guide.
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 AAH 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)	1. HMIS data from the Alameda County Social Health Information Exchange (SHIE) 2. Z-code data from AAH 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.

Data Source	Resourced From	RSS Incorporation
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 currently unavailable.	Gender identity is used in the calculation of the Johns Hopkins ACG metrics, which are incorporated in the RSS methodology. Sexual orientation data to be included when the DHCS PHM Service/RSS methodology is available.
Admissions, discharge, and transfer (ADT) data (NCQA PHM 2 Element 7: Advanced Data Sources)	1. ADT data received from facilities is stored in the AAH reporting databases	Data is used to assist with real-time Care Management (CM) program referral.
Referrals and authorizations	1. Referral and authorization data from AAH's clinical system, TruCare	Data is used to assist with real-time CM program referral. Data sources are also used to identify members who qualify as high risk based on the PHM Policy Guide.
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 AAH'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 and identification of high risk members based on the PHM Policy Guide Additional data to be included in the RSS methodology when the

Data Source	Resourced From	RSS Incorporation
		DHCS PHM Service is available.
Disengaged member reports (e.g., assigned members who have not utilized any services)	1. AAH 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 PHM Service is available.
Laboratory test results (NCQA PHM 2 Element 3: Laboratory Results)	1. Laboratory test results are collected from AAH's contracted laboratory providers. Data is stored in the AAH databases and utilized by AAH's NCQA certified HEDIS vendor, Cotiviti.	Laboratory test results are included in the calculation of HEDIS outcomes. 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 PHM Service 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 PHM Service 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 PHM Service is available.
Justice-involved data		Data to be included in the RSS methodology when the DHCS PHM Service is available.

Data Source	Resourced From	RSS Incorporation
Disability status		Data to be included in the RSS methodology when the DHCS PHM Service 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 PHM Service is available.

3. AAH 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. AAH 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 AAH databases for reporting, viewing, and historical purposes.

4. AAH 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, AAH 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 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 PHM Service RSS and risk tiering functionalities are available, the Alliance will:
   7.1. Utilize the PHM Service RSS outputs and tiers to support statewide standardization and comparisons. The PHM Service 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 PHM service 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 PHM Service 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 AAH RSS methodology when the DHCS PHM Service is implemented for the Medi-Cal population.

DEFINITIONS / ACRONYMS

AAH	Alameda Alliance for Health
ACG	Adjusted Clinical Groups
CCM	Complex Case Management
CS	Community Supports
DHCS	Department of Health Care Services
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
PHM Service	Statewide technology service designed to support PHM Program functions
RSS	Risk Stratification and Segmentation
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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

PH-001 Population Health Management (PHM) Program

REVISION HISTORY

New Policy 9/19/2023, TBA

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	BH-004
Policy Name	Behavioral Health Therapies (BHT): Applied Behavioral Analysis (ABA)
Department Name	Medical Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Medical Director / Senior Director of Behavioral Health
Lines of Business	Medi-Cal
Effective Date	4/10/2024
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/16/2024
Compliance Committee Approval Date	4/10/2024

POLICY STATEMENT

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

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

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

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

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

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

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

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

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

- Does not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.

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

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

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

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

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

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

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

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

5. The parent or guardian is instructed to submit a copy of the available information from the treating provider that must show that the member exhibits the presence of excessive and/or deficits of behaviors that significantly interfere with home and community activities.
6. The Alliance BCBA reviews the available information and confirms that the member is medically stable and without need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.
7. The Alliance BCBA conducts a thorough assessment of the Member's history and may request additional documentation from the parent or guardian, LEA or other treating provider to determine specific treatment needs and the number of hours needed for the initial Functional Behavioral Assessment (FBA)/Initial Assessment. This initial assessment completed by the Alliance BCBA may include one or more of the following:
    - Additional evaluations or diagnostic reports.
    - Release of Information form.
    - Individual Education Plan (IEP) report for the member.
    - Reports from therapists providing any other services.
    - Previous assessments/treatment plans if applicable.
    - Previous behavior plan if applicable.
8. The Alliance BCBA reviews the information provided by the parent or guardian, LEA or other treating provider including diagnostic and assessment information and follows the DHCS APL guidance, MCG guidelines and the Council of Autism Services Provider Guidelines available on the Behavioral Analysis Certification Board's website to refer for medically necessary CDE services if a current CDE is not already available.
9. The Alliance BCBA reviews the information provided by the parent or guardian, diagnostic and assessment information and follows the DHCS APL guidance, MCG guidelines and the Council of Autism Services Provider Guidelines available on the Behavior Analysis Certification Board's website. to refer the member to a Qualified Autism Service Provider for a medically necessary Functional Behavioral Assessment (FBA) if a current FBA is not already completed.
10. The Alliance BCBA reviews the FBA and provides authorization for 6 months of BHT services utilizing The DHCS APL guidance, MCG guidelines and the Board of Behavioral Analysis guidelines and ensures the treatment plan includes:
    - A description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures, results, and evidence based BHT services.
    - Delineation of both the frequency of baseline behaviors and the treatment planned to address the behaviors.
    - Identification of measurable long, intermediate, and short-term goals and objectives that are specific, behaviorally, defined, developmentally appropriate, socially significant, and based upon clinical observation.

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

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

    1) Services rendered when continued clinical benefit is not expected, unless the services are determined to be Medically Necessary.
    2) Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person (hereinafter, "Guardian") for costs associated with participation under the behavioral treatment plan.

3) Treatment where the sole purpose is vocationally- or recreationally-based.
4) Custodial care. For purposes of BHT services, custodial care:
a. Is provided primarily to maintain the Member's or anyone else's safety; and,
b. Could be provided by persons without professional skills or training.
5) Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
6) Services rendered by a parent or legal custodian.
7) Services that are not evidence-based behavioral intervention practice

12. Extension of Existing ABA Services:

- To request an extension on unused units close to when the authorization expires or after the existing authorization has expired, provider must do the following:
    - Submit the most current treatment plan with the data/updates they have available and justify why they were not able to provide the services/procedures approved in the existing authorization. The request should be submitted through the provider portal as a prior-auth request auth attached clinicals/treatment plan.
    - These types of requests will be authorized for 3 months instead of 6 months.
- The Alliance BCBAs will review each request on a case-by-case basis and determine if the request meets medica necessity.
- The Alliance BCBA or BH Navigator will send notification of determination to member, PCP, servicing provider, and rendering provider.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments responsible for clinical reviews

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program
UM-014 Identifying Abuse
UM-045 Communication Services
UM-048 Triage and Screening Services
UM-057 Authorization Requests
UM-059 Continuity of Care for Medi-Cal Beneficiaries Transitioning into Medi-Cal Managed Care
CM-001 CCM Identification Screening Enrollment and Assessment
CM-002 CCM Plan Development and Management
CM-004 Care Coordination
CM-011 ECM Care Management and Transitions of Care
MBR-062 Member Services Clinical Referral and Triage Process
CMP-008 Member Rights to Release PHI
QI – 108 Access to Behavioral Health Services
CLS-003 Language Assistance Services
BH-001 Behavioral Health Services
BH-002 Behavioral Health Services

RELATED WORKLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

New Policy : 4/10/2024

REFERENCES

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

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

- DHCS All Plan Letter (APL) 22-029 (Revised) Dyadic Services and Family Therapy Benefit
- DHCS All Plan Letter (APL) 18-014: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
- DHCS APL 21-002 Implementation of SB 855, MH/SUD Coverage
- DHCS APL 22-005 No Wrong Door for Mental Health Services
- DHCS APL 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders.
- DHCS APL 22-007 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Service
- Medi-Cal Provider Manual – Part 2: Psychological Services
- Title 9, California Code of Regulations, §§1810.370(a)(3), 1830.205 and 1830.210
- Title 22, California Code of Regulations, §51337
- AA. Welfare and Institutions Code, §§14132.03 and 14189 BB. Title 42, Code of Federal Regulations, Part 438, Subpart K CC. Title 42 Code of Federal Regulations §438.910(d)

MONITORING

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

POLICY AND PROCEDURE

Policy Number	QI-108
Policy Name	Access to Behavioral Health Services
Department Name	Quality Improvement
Department Officer	Chief Medical Officer
Policy Owner	Senior Director of Quality
Line(s) of Business	MCAL, IHSS
Effective Date	3/31/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~3/6/2024~~
Administrative Oversight Committee Approval Date	~~6/12/2024~~

POLICY STATEMENT

Alameda Alliance for Health (Alliance) ensures its provider network is sufficient to provide accessibility, availability, and continuity of covered 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), 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 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, afterhours 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 ~~parity~~ 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 access and availability reports ~~provided by the delegated behavioral health services organization~~, 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 Committee (QIHEC) 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.~~

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

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

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.

Commented [RR1]: Is this still true now that BH is no longer delegated?

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM-016
Policy Name	Transportation Guidelines
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	Medi-Cal
Effective Date	11/21/2006
Approval/Revision Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (Alliance) (AAH) provides the following transportation benefits to Medi-Cal members, including Long Term Care (LTC) members residing in Skilled Nursing Facilities (SNF), for all pharmacy, Medi-Cal Rx and medically necessary services, in network and out of network, covered by the Alliance:

- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Emergency Medical Transportation

Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, AAH has establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services, regardless of the member's coverage by another delivery system.

NEMT services are authorized under SSA Section 1902 (a)(70), under 42 U.S.C. section 1396a(a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2. Per Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), AAH covers NEMT for members to obtain pharmacy, Medi-Cal Rx and medically necessary Medi-Cal services covered by the Plan. Plans must provide NMT for Medi-Cal members to receive Medi-Cal services covered by the Plan, as well as other Medi-Cal services that are not covered under the Plan's Medi-Cal contractual requirements. AAH covers transportation-related travel expenses as set forth in 42 CFR section 440.170(a)(1) and (3), and the MCP Contract.

The Alliance provides these transportation services in accordance with time and distance and timely access standards, as specified in AB 1642. The Alliance also provides transportation services for trips outside of the time and distance standards via prior authorization. The Alliance

will assist to arrange transportation to appointments within applicable time and distance and timely access standards whenever needed, for in network or out of network providers, including whether or not a Letter of Agreement (LOA) with an Out of Network (OON) Provider is established. Transportation services (NMT or NEMT) are provided at no cost to the member.

AAH provides NMT for Medi-Cal services that are carved-out of the MCP Contract. These carved-out Medi-Cal services include, but are not limited to, specialty mental health services, substance use disorder services, dental services, and other services delivered through the Medi-Cal fee-for-service (FFS) delivery system. Carved-out services are not subject to AAH's utilization controls or bound by time or distance standards as these services are not authorized or arranged by AAH. Nonetheless, AAH will not deny NMT for an appointment to an out-of-network provider if the appointment is for a carved-out service and will provide the NMT service within timely access standards.

Members and SNF's where LTC members reside are informed of their right to obtain transportation services in the Member Handbook/Evidence of Coverage, including a description of the transportation benefit, the types of transportation services, and procedures to access transportation for both in network care and out of network care.

Non-Emergency Medical Transportation

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender, for the purposes of enabling a member to obtain medically necessary covered services or pharmacy prescriptions authorized by Medi-Cal Rx in network or out of network.

Prior Authorization – Trips over 50 miles

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All trips of 50 or more miles require prior authorization from the Alliance. Once prior authorization is processed by the Alliance, the Alliance forwards the authorization to the transportation subcontractor so that trip may be scheduled.

Prior Authorization - NEMT

NEMT services are subject to prior authorization in the form of a Physician Certification Statement (PCS). The member must have an approved Physician Certification Statement (PCS) form authorizing NEMT by the provider before the trip occurs. For AAH covered services in and out of network, AAH provides authorization for NEMT for the duration indicated by the treating medical professional on the PCS form,, not to exceed 12 months.

AAH provides medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. AAH provides NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. AAH has processes in place to ensure door-to-door assistance is being provided for all members receiving NEMT services.

AAH ensures that a medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with the MCP contract. AAH authorizes, at a minimum, the lowest cost type of NEMT service (see modalities below) that is adequate for the member's medical needs, as determined by the medical professional. AAH ensures that there are no limits to receiving NEMT if the member's services are medically necessary, and the member has prior authorization for the NEMT.

For Medi-Cal services that are not covered under the MCP Contract, AAH makes their best effort to refer and coordinate NEMT services. However, AAH provides medically appropriate NEMT services for their members for all pharmacy prescriptions prescribed by the member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

Prior Authorization Exceptions

A member or provider is not required to obtain prior authorization for NEMT services if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or imbedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.

Non-Emergency Medical Transportation Modalities

AAH provides the following four modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual and 22 CCR Section 51323 when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care: ambulance, litter van, wheelchair vain, or air transport. Additionally, AAH ensures that it or its transportation broker provides the appropriate modality prescribed by the member's provider in the PCS Form. AAH or its transportation brokers may not change the modality outlined in the PCS Form, or downgrade members' level of transportation from NEMT to NMT unless multiple modalities are selected in the PCS Form, in which case then AAH or its transportation broker may choose the lowest cost modality.

Non-Emergency Medical Transportation Scheduling and Timely Access

AAH ensures that they meet timely access standards as set forth in 28 CCR section 1300.67.2.2. The member's need for NEMT services does not relieve AAH from complying with timely access standard obligations. AAH notes in their Member Handbook the notification timeframe requirements for transportation requests and has a direct line to AAH's transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT transportation and receive status updates on their NEMT rides. The transportation liaison ensures that authorizations are being processed during and after business hours. AAH informs members that they must arrive within 15 minutes of their scheduled appointment. If the NEMT provider is late or does not arrive at the scheduled pick-up time for the member, AAH authorizes urgent NEMT to ensure the member does not miss their appointment.

AAH provides telephone authorization for NEMT requests when a member requires an AAH-covered medically necessary service of an urgent nature and a PCS form could not have reasonably been submitted beforehand. The member's provider must submit a PCS form post-service for the telephone authorization to be valid.

Additionally, to ensure a timely transfer, NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a psychiatric health facility, or any other appropriate inpatient acute psychiatric facility, are provided within 3 hours of the member or provider's request. If NEMT services are not provided within the 3 hour timeframe, the acute care hospital may arrange, and AAH will cover, out-of-network NEMT services.

AAH has a process in place to ensure their transportation brokers and providers are meeting these requirements and to impose corrective action on their transportation brokers if non-compliance is identified through oversight and monitoring activities.

Non-Emergency Medical Transportation Physician Certification Statement Forms

AAH utilizes a NEMT PCS form that has been approved by DHCS and includes the required components described below to arrange for NEMT services for its members. If AAH makes any changes to the PCS form since the last approval received from DHCS, AAH resubmits it for approval. The PCS form is used to determine the appropriate level of service for members. Once the member's treating provider prescribes the form of transportation, the AAH will not modify the authorization.

NEMT PCS forms must include, at a minimum, the following components:

- Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).
- Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

AAH ensures that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. AAH has a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their provider by telephone, electronically, or in person.

Use of Physician Certification Statement Forms

The member's provider must submit the PCS Form to the AAH for the approval of NEMT services and AAH uses the PCS form to provide the appropriate mode of NEMT for members. Once the member's treating provider prescribes the mode of NEMT, AAH does not modify the PCS Form. AAH has a process in place to share the PCS Form or communicate the approved mode of NEMT and dates of service to the NEMT broker or provider for the arrangement of NEMT services. AAH reviews and approves of the PCS. AAH will ensure that contracts with the transportation broker will comply with the requirements set forth in APL 17-004, APL 19-004, APL 21-011, APL 22-008, and the MCP Contract.

Non-Medical Transportation

AAH provides NMT services necessary for members to obtain medically necessary Medi-Cal services, including those not covered under the AAH contract. Services that are not covered under the AAH contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system, including pharmacy services provided to members through Medi-Cal Rx.

NMT services do not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans, all licensed, operated, and equipped in accordance with state and local statutes,

ordinances, or regulations. NMT services may be appropriate for members if they are currently using a wheelchair, but the limitation is such that the member is able to ambulate without assistance from the driver. AAH takes into consideration the member's abilities when scheduling the NMT service. The NMT service requested must be the least costly method of transportation that meets the member's needs.

AAH provides members with a Member Handbook that includes information on the procedures for obtaining NMT services. The Member Handbook includes a description of NMT services and the conditions under which NMT is available.

AAH provides the following NMT services:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle), including by ferry, as well as mileage reimbursement when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.
- Round trip NMT is available for the following:
  - Medically necessary covered services.
  - Members picking up drug prescriptions that cannot be mailed directly to the member.
  - Members picking up medical supplies, prosthetics, orthotics, and other equipment.

NMT is provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

AAH informs the members that they must arrive within 15 minutes of their scheduled appointment. If the NMT provider does not arrive at the scheduled pick-up time, AAH provides alternate NMT or allow the member to schedule alternate out-of-network NMT and reimburse for the out-of-network NEMT.

Conditions for Non-Medical Transportation Services:

- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior approval at time of the initial NMT request.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to AAH in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  - Has no valid driver's license;
  - Has no working vehicle available in the household;
  - Is unable to travel or wait for medical or dental services alone; or
  - Has a physical, cognitive, mental, or developmental limitation.

Commented [MJA1]: Added the APL language back about coverage for member and one attendants, but took out auth word--we would pay for a bus ticket for an attendant.

Non-Medical Transportation Private Vehicle Authorization Requirements

AAH authorizes the use of private conveyance (passenger vehicle) when no other methods of transportation are reasonably available to the member or provided by AAH. Private conveyance is transportation via a privately owned vehicle arranged by the member. This can include the member's personal vehicle, or that of a friend or family member. This does not include vehicles that are connected to businesses, such as Uber or Lyft. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to AAH stating other methods of transportation are not available. The attestation can be made over

the phone, electronically, or in person. To receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include:

- Valid driver's license;
- Valid vehicle registration; and
- Valid vehicle insurance.

AAH has policies and procedures to reimburse their members and only reimburses the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation.

Non-Medical Transportation Authorization
AAH does not require prior authorization for NMT services.

Minor Requirements
Unless otherwise provided by law, AAH provides NEMT or NMT for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, AAH may arrange NEMT or NMT services for a minor who is unaccompanied by a parent or a guardian. AAH will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service. AAH ensures that all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor. AAH does not arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless state or federal law does not require parental consent for minor's service.

Transportation Brokers
AAH subcontracts with a transportation broker for the provision of the NEMT or NMT services. The transportation broker has a network of NEMT or NMT providers to provide rides to members. AAH can supplement their transportation network if a transportation broker's network is not sufficient.

AAH does not delegate its obligations related to responsibility for monitoring and oversight of the network providers and subcontractors, grievances and appeals, enrollment of NEMT or NMT providers as Medi-Cal providers, or utilization management functions, including the review of PCS forms, to its transportation broker.

AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Transportation brokers do not triage the member's need to assess for the most appropriate level of NEMT service. Transportation broker arranges or provides the modality of transportation prescribed in the PCS Form. Transportation brokers do not downgrade the member's level of care from NEMT to NMT, including ambulatory door-to-door services.
AAH requires transportation brokers to have a process in place to identify specific NEMT or NMT providers, including the name of the drivers based on service date, time, pick-up/drop-off location, and member name. AAH also has a process in place for members to be able to identify specific drivers in a grievance.

Related Travel Expenses for Non-Emergency Medical Transportation and Non-Medical Transportation

AAH covers transportation-related travel expenses determined to be necessary for NEMT and NMT, including the cost of transportation and reasonably necessary expenses for meals and lodging for members receiving medically necessary covered services and their accompanying

attendant. AAH uses the IRS per diem rates for lodging and meals as a guide The salary of the accompanying attendant determined to be necessary is a covered travel expense as well if the attendant is not a family member, as set forth in 42 CFR section 440.170(a)(3)(iii). AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary. AAH still will require a PCS form for all NEMT authorizations. Transportation-related travel expenses are subject to retroactive reimbursement. To qualify for retroactive reimbursement of related travel expenses the underlying NEMT or NMT service and the related expenses must be appropriately documented in accordance with AAH's policies and procedures.

AAH notifies members of the process to request authorization for related travel expenses. If a member fails to comply with AAH's prior authorization process, AAH is not required to cover the member's related travel expenses.
A member is eligible for coverage of related travel expenses including, but not limited to, circumstances where the member is obtaining a medically necessary service that is not available within a reasonable distance from a member's home, such that the member is unable to make the trip within a reasonable time.

Payment
AAH has procedures in place to provide the following methods of payment for related travel expenses:

- Member Reimbursement: AAH reimburses members for approved travel expenses. Reimbursement must cover the actual expenses incurred by the member and the accompanying attendant if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals and lodging as a guide. If the member or the member's family paid for travel expenses up front, AAH approves and reimburses the member or member's family no later than 60 calendar days following confirmation that all required receipts and documentation have been received by AAH.
- Pre-payment to Broker: AAH will prepay Brokers for related travel expenses, including expenses for meals and lodging, if the member and the accompanying attendant are unable to pay in advance. The member must attest to AAH in person, electronically, or over the phone that they are unable to pay in advance for related travel expenses.
- AAH or Subcontractor will reimburse an Indian Health Care Provider (IHCP) that is enrolled in the Medi-Cal program for transporting an American Indian MCP Member to an IHCP regardless if the IHCP is contracted with AAH, as long as the transportation takes place using a PAVE approved transportation provider.

Lodging
If AAH does not prepay for the member's and accompanying attendant's lodging, AAH provides reimbursement for approved lodging expenses. Reimbursement must cover actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for lodging as a guide. As part of the prior authorization process, AAH may arrange lodging to be used by the member and accompanying attendant, so long as it is located within a reasonable distance from the location where the member will obtain medically necessary services.

Meals
If AAH does not prepay for the member's and accompanying attendant's meals, AAH will provide reimbursement for approved meal expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals as a guide. Hospital meal voucher(s) may be deducted from the meal expenses submitted by a member and accompanying attendant.

Other Necessary Expenses
If AAH does not prepay for other necessary expenses (e.g., parking, tolls) incurred by the member and accompanying attendant, the AAH provides reimbursement for other necessary expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts.

Enrollment of Transportation Providers
AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Major Organ Transplant
AAH provides Major Organ Transplant (MOT) donors NEMT or NMT transportation at the request of the MOT donor or the member who is the recipient. PCS forms are not required for MOT donors requesting NEMT services to ensure the donor can get to the hospital for the MOT transplant.
AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary for the member and the donor. AAH allows an attendant for the donor if AAH determines that an attendant to accompany the donor is necessary.
AAH also covers travel expenses for MOT donors as described in the Travel Expenses section of this policy.

AAH Monitoring and Oversight
AAH ensures that their network providers and subcontractors, including transportation brokers, comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements are communicated to all subcontractors and network providers.
AAH is responsible for monitoring and overseeing their transportation brokers to ensure that transportation brokers are complying with the requirements set forth in APL 22-008 and all applicable state and federal laws and regulations, contractual requirement and other DHCS guidance such as APLs and Policy letters. AAH conducts monitoring activities no less than quarterly. Monitoring activities may include, but are not limited to, verification of the following items:

- Enrollment status of NEMT and NMT providers;
- The transportation broker is not modifying the level of transportation service outlined in the PCS Form; and
- The NEMT provider is providing door-to-door assistance for members receiving NEMT services.
- NEMT and NMT providers are consistently arriving within 15 minutes of scheduled time for appointments;
- No show rates for NEMT and NMT providers;
- AAH has a process in place to impose corrective action on their transportation brokers and network providers if non-compliance with APL 22-008 or other applicable regulations is identified through any monitoring or oversight activities.

PROCEDURE

The Alliance provides the lowest cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by

the Alliance and its transportation broker. The following guidelines will be used when reviewing requests for transportation services:

1. **Non-Emergency Medical Transportation** (NEMT) is covered for pharmacy, Medi-Cal Rx and all medically necessary Medi-Cal services covered by the Alliance. The Alliance shall provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT is provided for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Alliance shall ensure door-to-door assistance for all members receiving NEMT services. The Alliance will assist members to make arrangements for NEMT whenever requested. The Alliance shall ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS. Requests for transportation services must be submitted and must meet the following requirements:

i) The Alliance's Physician Certification Statement (PCS) form signed by the treating physician or mid-level provider (MD, DO, Dentist, Podiatrist, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Physical Therapist, Speech Therapist, Occupational Therapist or Mental Health or Substance Use Disorder Provider) is required in order to determine the appropriate level of service.

ii) PAs, NPs and CNMs may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and are subject to the supervising physician and PA/NP/CNM being enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 Part 3 of Division 9 of the *Welfare and Institutions Code* (W&I Code).

AAH uses the Department of Health Care Services (DHCS) approved PCS form.

iii) At a minimum, the following components are included in the PCS form:

(a) Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

(b) Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.

(c) Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).

(i) Ambulance services will be provided for:

1. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.
2. Transfers from an acute care facility to another acute care facility.
3. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
4. Transport for members with chronic conditions who require oxygen if monitoring is required.

(ii) Litter van services will be provided when both of the following are met:

1. Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
2. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(iii) Wheelchair van services will be provided when any of the following are met:

1. Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
2. Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
3. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
4. Members who suffer from severe mental confusion.
5. Members with paraplegia.
6. Dialysis recipients.
7. Members with chronic conditions who require oxygen but do not require monitoring.

(iv) Air transport will be provided under the following conditions:

1. When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or a mental health or substance use disorder provider.

Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

(d) The signed PCS form with the required fields will be considered completed.

(e) The completed PCS form must be submitted to AAH for coordination of services. Submission must occur before NEMT services can be prescribed and provided to the member.

(f) Once the completed PCS form is received by AAH, it may not be modified. The Alliance and its transportation broker coordinate with the prescribing provider to ensure the PCS form submitted captures the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.

(g) The Alliance captures data from the PCS form for reporting and submitting the data to the DHCS.

iv) NEMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

(a) Authorization for NEMT requests can be given by phone when a member requires a medically necessary service of an urgent nature and a PCS form cannot be reasonably submitted beforehand. In urgent situations in which the delay in transportation would result in harm to the member, the transportation broker or the Alliance will obtain the form:

(i) In the absence of a PCS form, the transportation Broker staff member asks questions to ascertain the level of support or supervision the member will require during the transport, including cognitive and safety status. The PCS form will be obtained post-service to be considered a valid PCS authorization.

v) For Medi-Cal services not covered by the Plan, including specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system or California Children's Services (CCS), the Alliance makes its best effort to refer and coordinate NEMT for members whose condition necessitates one of the above forms of transportation.

2. **Non-Medical Transportation** (NMT) is covered for all round-trip transportation to medically necessary services covered by Medi-Cal. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances. Requests are submitted to and processed by the Alliance's transportation broker. The Alliance shall provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws. The Alliance will assist members to make arrangements for NMT whenever requested.

i) Providers or members may call the Alliance or its transportation broker directly to request for NMT services.

(a) Round trip NMT is available for the following:

(i) Medically necessary covered services

(ii) Members picking up drug prescriptions that cannot be mailed directly to the member

(iii) Member picking up medical supplies, prosthetics, orthotics and other equipment.

(b) NMT is provided in a form and manner that is accessible, in terms of physical and geographical accessibility, for the member and consistent with applicable state and federal disability right laws.

(c) Conditions for NMT services:

(i) NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of the initial NMT authorization request.

(ii) NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

(iii) For private conveyance, the member must attest to the AAH in person, electronically, or over the phone that other transportation resources have been

reasonably exhausted. The attestation may include confirmation that the member:

1. Has no valid driver's license;
2. Has no working vehicle available in the household;
3. Is unable to travel or wait for medical or dental services alone; or
4. Has a physical, cognitive, mental, or developmental limitation.

ii) NMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

iii) NMT is provided using the lowest cost modality appropriate for the member's condition. NMT modalities include the following:

(a) Public transportation/mass transit (bus passes)

(b) East Bay Paratransit

(c) Taxicab/Curb-to-curb passenger vehicle (including tax vouchers)

(d) Door-to-door passenger vehicle

(e) Train tickets

(f) Any other form of private conveyance (private vehicle), including by ferry, as well as mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged by the member and not through a transportation broker.

(i) To receive gas mileage reimbursement for use of a private vehicle, the following documentation must be submitted to the Alliance's transportation broker to document compliance with all California driving requirements, including:

1. Valid driver's license,
2. Valid vehicle registration, and
3. Valid vehicle insurance.

iv) NMT services for Medi-Cal carved out services will be provided upon member or provider request to the Alliance. NMT can continue to be provided through Medi-Cal Fee for Service agencies, such as CCS, if requested directly to the agency.

3. Emergency Medical Transportation: is provided when a member's medical condition is acute and severe, necessitating immediate medical diagnosis to prevent death or disability. Requests do not require prior authorization. The following guidelines apply to Emergency Medical Transportation:

i) Emergency Medical Transportation by air is covered only when medically necessary and when other forms of transportation are not practical or feasible for the patient's condition.

ii) Ground Emergency Medical Transportation is covered when ordinary public or

private medical transportation is medically contraindicated, and transportation is needed to obtain care.

iii) Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.

iv) Medical transportation which represents a continuation of an original emergency transportation event does not require prior authorization.

Requests for transportation services must be requested by calling the Alliance's broker. Requests may take at least one (1) business day to process before the requested service can be provided, although there are exceptions for situations such as hospital discharges, which must be provided within 3 hours of the request. Requests for public transportation or East Bay Paratransit require time for mailing the member vouchers prior to attending their scheduled appointment.

4. Prior Authorization Process

i) Upon receipt, AAH's Case Management Department reviews the PCS form for completeness and accuracy. If PCS form incomplete or with error, AAH will contact member's treating provider requesting updated PCS form with corrections. Upon receipt of complete and accurate PCS form, AAH will share form with transportation vendor.

(a) If member requests NEMT for a service of urgent nature, transportation vendor will schedule service based on AAH approved urgent treatment type. AAH will follow up with member's treating provider to obtain completed PCS form.

5. Emergency Arising during Transport of a member

a. Emergencies arising in the course of a transport may include, but not be limited to the following:
   i. Sudden onset of a new emergency medical condition
   ii. Motor vehicle accident resulting in the injury of a member.
   iii. Member elopement during the transport
   iv. Member attempt of or actual self-harm or harm of others
   v. Other unexpected events that have the potential to result in harm to the member.

b. In the event that an emergency arises during the transport of a member, the transportation broker staff will follow the emergency policies and procedures of the transportation broker, with a focus on ensuring the safety of the member and mitigation of potential harm to the member.

c. The transportation broker will inform AAH of the emergency event involving the member as soon as practical after the emergency situation has stabilized by contacting the Grievance Department by email to grievances@alamedaalliance.org, and by phone to the Grievance and Appeal Department at (510) 747-4531.

d. The Grievance and Appeal staff member receiving the communication about the emergency situation from the transportation broker will escalate the situation to the leadership of AAH, following the chain of command.

e. Actions taken in relation to the emergency event will be determined by AAH leadership at the division level, such as CMO or COO.

6. **RideShare Pilot**

In 2023, AAH will implement a RideShare pilot for recovery rides only. A recovery ride is defined as a backup transportation option should member's original ride with driver not show up on time or not show up at all. Should this occur, broker may offer member a Lyft RideShare if there are no other types of drivers available and member does not have any medical needs that do not allow member to use a car, bus or taxi to get to appointments. Member cannot request that a Lyft RideShare be used for initial ride requests or any other ride requests. Reimbursement for any Lyft or other RideShare trips (i.e., Lyft, Uber) will not be allowed.

DEFINITIONS

Emergency Medical Condition: A medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the members health in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

AFFECTED DEPARTMENTS/PARTIES

Member Services
Provider Relations
Vendor Management
Grievance & Appeal
Case & Disease Management

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Physician Certification Statement (PCS) form
Alliance Evidence of Coverage (EOC)

Transportation Template
UM-002 Coordination of Care

REVISION HISTORY

1/1/2008, 10/28/2009, 11/19/2010, 8/30/2012, 1/7/2014, 01/10/2016, 12/15/2016, 8/24/2017, 08/03/2018, 09/06/2018, 11/21/2019, 1/21/21, 5/20/2021, 6/28/2022, 02/21/2023

REFERENCES

AB 2394, Chapter 615, Statutes of 2016California Bridge to Reform Demonstration No. 11-W-00193/9, § 81.f.ix
AB 1642, Wood. Medi-Cal: Managed Care Plans (1)
DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services
APL 17-004 Subcontractual Relationships and Delegation
APL 19-004 Provider Credentialing/Recredentialing and Screening/Enrollment
APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights' Templates
DHCS MCP Contract.
Federal Statute 420.5.C.S 1396b [V])
Medi-Cal Criteria Manual Chapter 12.1
Title 22 CCR, Section 51056(a)
Title 28 CCR, Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)
Title 28 CCR, Section 1300.67(g)(1)

MONITORING

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

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	UM-016
Policy Name	Transportation Guidelines
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	Medi-Cal
Effective Date	11/21/2006
Approval/Revision Date	TBD

POLICY STATEMENT

Alameda Alliance for Health (Alliance) (AAH) provides the following transportation benefits to Medi-Cal members, including Long Term Care (LTC) members residing in Skilled Nursing Facilities (SNF), for all pharmacy, Medi-Cal Rx and medically necessary services, in network and out of network, covered by the Alliance:

- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Emergency Medical Transportation

Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, AAH has establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services, regardless of the member's coverage by another delivery system.

NEMT services are authorized under SSA Section 1902 (a)(70), under 42 U.S.C. section 1396a(a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2. Per Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), AAH covers NEMT for members to obtain pharmacy, Medi-Cal Rx and medically necessary Medi-Cal services covered by the Plan. Plans must provide NMT for Medi-Cal members to receive Medi-Cal services covered by the Plan, as well as other Medi-Cal services that are not covered under the Plan's Medi-Cal contractual requirements. AAH covers transportation-related travel expenses as set forth in 42 CFR section 440.170(a)(1) and (3), and the MCP Contract.

The Alliance provides these transportation services in accordance with time and distance and timely access standards, as specified in AB 1642. The Alliance also provides transportation services for trips outside of the time and distance standards via prior authorization. The Alliance

will assist to arrange transportation to appointments within applicable time and distance and timely access standards whenever needed, for in network or out of network providers, including whether or not a Letter of Agreement (LOA) with an Out of Network (OON) Provider is established. Transportation services (NMT or NEMT) are provided at no cost to the member.

AAH provides NMT for Medi-Cal services that are carved-out of the MCP Contract. These carved-out Medi-Cal services include, but are not limited to, specialty mental health services, substance use disorder services, dental services, and other services delivered through the Medi-Cal fee-for-service (FFS) delivery system. Carved-out services are not subject to AAH's utilization controls or bound by time or distance standards as these services are not authorized or arranged by AAH. Nonetheless, AAH will not deny NMT for an appointment to an out-of-network provider if the appointment is for a carved-out service and will provide the NMT service within timely access standards.

Members and SNF's where LTC members reside are informed of their right to obtain transportation services in the Member Handbook/Evidence of Coverage, including a description of the transportation benefit, the types of transportation services, and procedures to access transportation for both in network care and out of network care.

Non-Emergency Medical Transportation

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender, for the purposes of enabling a member to obtain medically necessary covered services or pharmacy prescriptions authorized by Medi-Cal Rx in network or out of network.

Prior Authorization – Trips over 50 miles

All trips of 50 or more miles require prior authorization from the Alliance. Once prior authorization is processed by the Alliance, the Alliance forwards the authorization to the transportation subcontractor so that trip may be scheduled.

Prior Authorization - NEMT

NEMT services are subject to prior authorization in the form of a Physician Certification Statement (PCS). The member must have an approved Physician Certification Statement (PCS) form authorizing NEMT by the provider before the trip occurs. For AAH covered services in and out of network, AAH provides authorization for NEMT for the duration indicated by the treating medical professional on the PCS form,, not to exceed 12 months.

AAH provides medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. AAH provides NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. AAH has processes in place to ensure door-to-door assistance is being provided for all members receiving NEMT services.

AAH ensures that a medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with the MCP contract. AAH authorizes, at a minimum, the lowest cost type of NEMT service (see modalities below) that is adequate for the member's medical needs, as determined by the medical professional. AAH ensures that there are no limits to receiving NEMT if the member's services are medically necessary, and the member has prior authorization for the NEMT.

For Medi-Cal services that are not covered under the MCP Contract, AAH makes their best effort to refer and coordinate NEMT services. However, AAH provides medically appropriate NEMT services for their members for all pharmacy prescriptions prescribed by the member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

Prior Authorization Exceptions

A member or provider is not required to obtain prior authorization for NEMT services if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or imbedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.

Non-Emergency Medical Transportation Modalities

AAH provides the following four modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual and 22 CCR Section 51323 when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care: ambulance, litter van, wheelchair vain, or air transport. Additionally, AAH ensures that it or its transportation broker provides the appropriate modality prescribed by the member's provider in the PCS Form. AAH or its transportation brokers may not change the modality outlined in the PCS Form, or downgrade members' level of transportation from NEMT to NMT unless multiple modalities are selected in the PCS Form, in which case then AAH or its transportation broker may choose the lowest cost modality.

Non-Emergency Medical Transportation Scheduling and Timely Access

AAH ensures that they meet timely access standards as set forth in 28 CCR section 1300.67.2.2. The member's need for NEMT services does not relieve AAH from complying with timely access standard obligations. AAH notes in their Member Handbook the notification timeframe requirements for transportation requests and has a direct line to AAH's transportation liaison for providers and members to call, request, and schedule urgent and non-urgent NEMT transportation and receive status updates on their NEMT rides. The transportation liaison ensures that authorizations are being processed during and after business hours. AAH informs members that they must arrive within 15 minutes of their scheduled appointment. If the NEMT provider is late or does not arrive at the scheduled pick-up time for the member, AAH authorizes urgent NEMT to ensure the member does not miss their appointment.

AAH provides telephone authorization for NEMT requests when a member requires an AAH-covered medically necessary service of an urgent nature and a PCS form could not have reasonably been submitted beforehand. The member's provider must submit a PCS form post-service for the telephone authorization to be valid.

Additionally, to ensure a timely transfer, NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a psychiatric health facility, or any other appropriate inpatient acute psychiatric facility, are provided within 3 hours of the member or provider's request. If NEMT services are not provided within the 3 hour timeframe, the acute care hospital may arrange, and AAH will cover, out-of-network NEMT services.

AAH has a process in place to ensure their transportation brokers and providers are meeting these requirements and to impose corrective action on their transportation brokers if non-compliance is identified through oversight and monitoring activities.

Non-Emergency Medical Transportation Physician Certification Statement Forms

AAH utilizes a NEMT PCS form that has been approved by DHCS and includes the required components described below to arrange for NEMT services for its members. If AAH makes any changes to the PCS form since the last approval received from DHCS, AAH resubmits it for approval. The PCS form is used to determine the appropriate level of service for members. Once the member's treating provider prescribes the form of transportation, the AAH will not modify the authorization.

NEMT PCS forms must include, at a minimum, the following components:

- Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).
- Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

AAH ensures that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. AAH has a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their provider by telephone, electronically, or in person.

Use of Physician Certification Statement Forms

The member's provider must submit the PCS Form to the AAH for the approval of NEMT services and AAH uses the PCS form to provide the appropriate mode of NEMT for members. Once the member's treating provider prescribes the mode of NEMT, AAH does not modify the PCS Form. AAH has a process in place to share the PCS Form or communicate the approved mode of NEMT and dates of service to the NEMT broker or provider for the arrangement of NEMT services. AAH reviews and approves of the PCS. AAH will ensure that contracts with the transportation broker will comply with the requirements set forth in APL 17-004, APL 19-004, APL 21-011, APL 22-008, and the MCP Contract.

Non-Medical Transportation

AAH provides NMT services necessary for members to obtain medically necessary Medi-Cal services, including those not covered under the AAH contract. Services that are not covered under the AAH contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system, including pharmacy services provided to members through Medi-Cal Rx.

NMT services do not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans, all licensed, operated, and equipped in accordance with state and local statutes,

ordinances, or regulations. NMT services may be appropriate for members if they are currently using a wheelchair, but the limitation is such that the member is able to ambulate without assistance from the driver. AAH takes into consideration the member's abilities when scheduling the NMT service. The NMT service requested must be the least costly method of transportation that meets the member's needs.

AAH provides members with a Member Handbook that includes information on the procedures for obtaining NMT services. The Member Handbook includes a description of NMT services and the conditions under which NMT is available.

AAH provides the following NMT services:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle), including by ferry, as well as mileage reimbursement when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.
- Round trip NMT is available for the following:
  - Medically necessary covered services.
  - Members picking up drug prescriptions that cannot be mailed directly to the member.
  - Members picking up medical supplies, prosthetics, orthotics, and other equipment.

NMT is provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

AAH informs the members that they must arrive within 15 minutes of their scheduled appointment. If the NMT provider does not arrive at the scheduled pick-up time, AAH provides alternate NMT or allow the member to schedule alternate out-of-network NMT and reimburse for the out-of-network NEMT.

Conditions for Non-Medical Transportation Services:

- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior approval at time of the initial NMT request.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to AAH in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  - Has no valid driver's license;
  - Has no working vehicle available in the household;
  - Is unable to travel or wait for medical or dental services alone; or
  - Has a physical, cognitive, mental, or developmental limitation.

Commented [MJA1]: Added the APL language back about coverage for member and one attendants, but took out auth word--we would pay for a bus ticket for an attendant.

Non-Medical Transportation Private Vehicle Authorization Requirements

AAH authorizes the use of private conveyance (passenger vehicle) when no other methods of transportation are reasonably available to the member or provided by AAH. Private conveyance is transportation via a privately owned vehicle arranged by the member. This can include the member's personal vehicle, or that of a friend or family member. This does not include vehicles that are connected to businesses, such as Uber or Lyft. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to AAH stating other methods of transportation are not available. The attestation can be made over

the phone, electronically, or in person. To receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include:

- Valid driver's license;
- Valid vehicle registration; and
- Valid vehicle insurance.

AAH has policies and procedures to reimburse their members and only reimburses the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation.

Non-Medical Transportation Authorization
AAH does not require prior authorization for NMT services.

Minor Requirements
Unless otherwise provided by law, AAH provides NEMT or NMT for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, AAH may arrange NEMT or NMT services for a minor who is unaccompanied by a parent or a guardian. AAH will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service. AAH ensures that all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor. AAH does not arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless state or federal law does not require parental consent for minor's service.

Transportation Brokers
AAH subcontracts with a transportation broker for the provision of the NEMT or NMT services. The transportation broker has a network of NEMT or NMT providers to provide rides to members. AAH can supplement their transportation network if a transportation broker's network is not sufficient.

AAH does not delegate its obligations related to responsibility for monitoring and oversight of the network providers and subcontractors, grievances and appeals, enrollment of NEMT or NMT providers as Medi-Cal providers, or utilization management functions, including the review of PCS forms, to its transportation broker.

AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Transportation brokers do not triage the member's need to assess for the most appropriate level of NEMT service. Transportation broker arranges or provides the modality of transportation prescribed in the PCS Form. Transportation brokers do not downgrade the member's level of care from NEMT to NMT, including ambulatory door-to-door services.
AAH requires transportation brokers to have a process in place to identify specific NEMT or NMT providers, including the name of the drivers based on service date, time, pick-up/drop-off location, and member name. AAH also has a process in place for members to be able to identify specific drivers in a grievance.

Related Travel Expenses for Non-Emergency Medical Transportation and Non-Medical Transportation

AAH covers transportation-related travel expenses determined to be necessary for NEMT and NMT, including the cost of transportation and reasonably necessary expenses for meals and lodging for members receiving medically necessary covered services and their accompanying

attendant. AAH uses the IRS per diem rates for lodging and meals as a guide The salary of the accompanying attendant determined to be necessary is a covered travel expense as well if the attendant is not a family member, as set forth in 42 CFR section 440.170(a)(3)(iii). AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary. AAH still will require a PCS form for all NEMT authorizations. Transportation-related travel expenses are subject to retroactive reimbursement. To qualify for retroactive reimbursement of related travel expenses the underlying NEMT or NMT service and the related expenses must be appropriately documented in accordance with AAH's policies and procedures.

AAH notifies members of the process to request authorization for related travel expenses. If a member fails to comply with AAH's prior authorization process, AAH is not required to cover the member's related travel expenses.
A member is eligible for coverage of related travel expenses including, but not limited to, circumstances where the member is obtaining a medically necessary service that is not available within a reasonable distance from a member's home, such that the member is unable to make the trip within a reasonable time.

Payment
AAH has procedures in place to provide the following methods of payment for related travel expenses:

- Member Reimbursement: AAH reimburses members for approved travel expenses. Reimbursement must cover the actual expenses incurred by the member and the accompanying attendant if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals and lodging as a guide. If the member or the member's family paid for travel expenses up front, AAH approves and reimburses the member or member's family no later than 60 calendar days following confirmation that all required receipts and documentation have been received by AAH.
- Pre-payment to Broker: AAH will prepay Brokers for related travel expenses, including expenses for meals and lodging, if the member and the accompanying attendant are unable to pay in advance. The member must attest to AAH in person, electronically, or over the phone that they are unable to pay in advance for related travel expenses.
- AAH or Subcontractor will reimburse an Indian Health Care Provider (IHCP) that is enrolled in the Medi-Cal program for transporting an American Indian MCP Member to an IHCP regardless if the IHCP is contracted with AAH, as long as the transportation takes place using a PAVE approved transportation provider.

Lodging
If AAH does not prepay for the member's and accompanying attendant's lodging, AAH provides reimbursement for approved lodging expenses. Reimbursement must cover actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for lodging as a guide. As part of the prior authorization process, AAH may arrange lodging to be used by the member and accompanying attendant, so long as it is located within a reasonable distance from the location where the member will obtain medically necessary services.

Meals
If AAH does not prepay for the member's and accompanying attendant's meals, AAH will provide reimbursement for approved meal expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts. AAH references the IRS per diem rates for meals as a guide. Hospital meal voucher(s) may be deducted from the meal expenses submitted by a member and accompanying attendant.

Other Necessary Expenses
If AAH does not prepay for other necessary expenses (e.g., parking, tolls) incurred by the member and accompanying attendant, the AAH provides reimbursement for other necessary expenses. Reimbursement must cover the actual expenses if those expenses are reasonable and supported by receipts.

Enrollment of Transportation Providers
AAH monitors Transportation Providers to ensure enrollment as Medi-Cal Providers. Please see policy VMG-005 Transportation Provider Registration with DHCS.

Major Organ Transplant
AAH provides Major Organ Transplant (MOT) donors NEMT or NMT transportation at the request of the MOT donor or the member who is the recipient. PCS forms are not required for MOT donors requesting NEMT services to ensure the donor can get to the hospital for the MOT transplant.
AAH uses prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary for the member and the donor. AAH allows an attendant for the donor if AAH determines that an attendant to accompany the donor is necessary.
AAH also covers travel expenses for MOT donors as described in the Travel Expenses section of this policy.

AAH Monitoring and Oversight
AAH ensures that their network providers and subcontractors, including transportation brokers, comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements are communicated to all subcontractors and network providers.
AAH is responsible for monitoring and overseeing their transportation brokers to ensure that transportation brokers are complying with the requirements set forth in APL 22-008 and all applicable state and federal laws and regulations, contractual requirement and other DHCS guidance such as APLs and Policy letters. AAH conducts monitoring activities no less than quarterly. Monitoring activities may include, but are not limited to, verification of the following items:

- Enrollment status of NEMT and NMT providers;
- The transportation broker is not modifying the level of transportation service outlined in the PCS Form; and
- The NEMT provider is providing door-to-door assistance for members receiving NEMT services.
- NEMT and NMT providers are consistently arriving within 15 minutes of scheduled time for appointments;
- No show rates for NEMT and NMT providers;
- AAH has a process in place to impose corrective action on their transportation brokers and network providers if non-compliance with APL 22-008 or other applicable regulations is identified through any monitoring or oversight activities.

PROCEDURE

The Alliance provides the lowest cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by

the Alliance and its transportation broker. The following guidelines will be used when reviewing requests for transportation services:

1. **Non-Emergency Medical Transportation** (NEMT) is covered for pharmacy, Medi-Cal Rx and all medically necessary Medi-Cal services covered by the Alliance. The Alliance shall provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT is provided for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Alliance shall ensure door-to-door assistance for all members receiving NEMT services. The Alliance will assist members to make arrangements for NEMT whenever requested. The Alliance shall ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS. Requests for transportation services must be submitted and must meet the following requirements:

i) The Alliance's Physician Certification Statement (PCS) form signed by the treating physician or mid-level provider (MD, DO, Dentist, Podiatrist, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, Physical Therapist, Speech Therapist, Occupational Therapist or Mental Health or Substance Use Disorder Provider) is required in order to determine the appropriate level of service.

ii) PAs, NPs and CNMs may sign authorization forms required by the department for covered benefits and services that are consistent with applicable state and federal law and are subject to the supervising physician and PA/NP/CNM being enrolled as Medi-Cal providers pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 Part 3 of Division 9 of the *Welfare and Institutions Code* (W&I Code).

AAH uses the Department of Health Care Services (DHCS) approved PCS form.

iii) At a minimum, the following components are included in the PCS form:

(a) Function Limitations Justification: For NEMT, the provider is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

(b) Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.

(c) Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance, litter van, wheelchair van, or air transport).

(i) Ambulance services will be provided for:

1. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.
2. Transfers from an acute care facility to another acute care facility.
3. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
4. Transport for members with chronic conditions who require oxygen if monitoring is required.

(ii) Litter van services will be provided when both of the following are met:

1. Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
2. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(iii) Wheelchair van services will be provided when any of the following are met:

1. Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
2. Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
3. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
4. Members who suffer from severe mental confusion.
5. Members with paraplegia.
6. Dialysis recipients.
7. Members with chronic conditions who require oxygen but do not require monitoring.

(iv) Air transport will be provided under the following conditions:

1. When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or a mental health or substance use disorder provider.

Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

(d) The signed PCS form with the required fields will be considered completed.

(e) The completed PCS form must be submitted to AAH for coordination of services. Submission must occur before NEMT services can be prescribed and provided to the member.

(f) Once the completed PCS form is received by AAH, it may not be modified. The Alliance and its transportation broker coordinate with the prescribing provider to ensure the PCS form submitted captures the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.

(g) The Alliance captures data from the PCS form for reporting and submitting the data to the DHCS.

iv) NEMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

(a) Authorization for NEMT requests can be given by phone when a member requires a medically necessary service of an urgent nature and a PCS form cannot be reasonably submitted beforehand. In urgent situations in which the delay in transportation would result in harm to the member, the transportation broker or the Alliance will obtain the form:

(i) In the absence of a PCS form, the transportation Broker staff member asks questions to ascertain the level of support or supervision the member will require during the transport, including cognitive and safety status. The PCS form will be obtained post-service to be considered a valid PCS authorization.

v) For Medi-Cal services not covered by the Plan, including specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system or California Children's Services (CCS), the Alliance makes its best effort to refer and coordinate NEMT for members whose condition necessitates one of the above forms of transportation.

2. **Non-Medical Transportation** (NMT) is covered for all round-trip transportation to medically necessary services covered by Medi-Cal. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances. Requests are submitted to and processed by the Alliance's transportation broker. The Alliance shall provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws. The Alliance will assist members to make arrangements for NMT whenever requested.

i) Providers or members may call the Alliance or its transportation broker directly to request for NMT services.

(a) Round trip NMT is available for the following:

(i) Medically necessary covered services

(ii) Members picking up drug prescriptions that cannot be mailed directly to the member

(iii) Member picking up medical supplies, prosthetics, orthotics and other equipment.

(b) NMT is provided in a form and manner that is accessible, in terms of physical and geographical accessibility, for the member and consistent with applicable state and federal disability right laws.

(c) Conditions for NMT services:

(i) NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of the initial NMT authorization request.

(ii) NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

(iii) For private conveyance, the member must attest to the AAH in person, electronically, or over the phone that other transportation resources have been

reasonably exhausted. The attestation may include confirmation that the member:

1. Has no valid driver's license;
2. Has no working vehicle available in the household;
3. Is unable to travel or wait for medical or dental services alone; or
4. Has a physical, cognitive, mental, or developmental limitation.

ii) NMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with written consent of a parent or guardian or when applicable State or federal law does not require parental consent for the minor's service.

iii) NMT is provided using the lowest cost modality appropriate for the member's condition. NMT modalities include the following:

(a) Public transportation/mass transit (bus passes)

(b) East Bay Paratransit

(c) Taxicab/Curb-to-curb passenger vehicle (including tax vouchers)

(d) Door-to-door passenger vehicle

(e) Train tickets

(f) Any other form of private conveyance (private vehicle), including by ferry, as well as mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged by the member and not through a transportation broker.

(i) To receive gas mileage reimbursement for use of a private vehicle, the following documentation must be submitted to the Alliance's transportation broker to document compliance with all California driving requirements, including:

1. Valid driver's license,
2. Valid vehicle registration, and
3. Valid vehicle insurance.

iv) NMT services for Medi-Cal carved out services will be provided upon member or provider request to the Alliance. NMT can continue to be provided through Medi-Cal Fee for Service agencies, such as CCS, if requested directly to the agency.

3. Emergency Medical Transportation: is provided when a member's medical condition is acute and severe, necessitating immediate medical diagnosis to prevent death or disability. Requests do not require prior authorization. The following guidelines apply to Emergency Medical Transportation:

i) Emergency Medical Transportation by air is covered only when medically necessary and when other forms of transportation are not practical or feasible for the patient's condition.

ii) Ground Emergency Medical Transportation is covered when ordinary public or

private medical transportation is medically contraindicated, and transportation is needed to obtain care.

iii) Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.

iv) Medical transportation which represents a continuation of an original emergency transportation event does not require prior authorization.

Requests for transportation services must be requested by calling the Alliance's broker. Requests may take at least one (1) business day to process before the requested service can be provided, although there are exceptions for situations such as hospital discharges, which must be provided within 3 hours of the request. Requests for public transportation or East Bay Paratransit require time for mailing the member vouchers prior to attending their scheduled appointment.

4. Prior Authorization Process

i) Upon receipt, AAH's Case Management Department reviews the PCS form for completeness and accuracy. If PCS form incomplete or with error, AAH will contact member's treating provider requesting updated PCS form with corrections. Upon receipt of complete and accurate PCS form, AAH will share form with transportation vendor.

(a) If member requests NEMT for a service of urgent nature, transportation vendor will schedule service based on AAH approved urgent treatment type. AAH will follow up with member's treating provider to obtain completed PCS form.

5. Emergency Arising during Transport of a member

a. Emergencies arising in the course of a transport may include, but not be limited to the following:
   i. Sudden onset of a new emergency medical condition
   ii. Motor vehicle accident resulting in the injury of a member.
   iii. Member elopement during the transport
   iv. Member attempt of or actual self-harm or harm of others
   v. Other unexpected events that have the potential to result in harm to the member.

b. In the event that an emergency arises during the transport of a member, the transportation broker staff will follow the emergency policies and procedures of the transportation broker, with a focus on ensuring the safety of the member and mitigation of potential harm to the member.

c. The transportation broker will inform AAH of the emergency event involving the member as soon as practical after the emergency situation has stabilized by contacting the Grievance Department by email to grievances@alamedaalliance.org, and by phone to the Grievance and Appeal Department at (510) 747-4531.

d. The Grievance and Appeal staff member receiving the communication about the emergency situation from the transportation broker will escalate the situation to the leadership of AAH, following the chain of command.

e. Actions taken in relation to the emergency event will be determined by AAH leadership at the division level, such as CMO or COO.

6. **RideShare Pilot**

In 2023, AAH will implement a RideShare pilot for recovery rides only. A recovery ride is defined as a backup transportation option should member's original ride with driver not show up on time or not show up at all. Should this occur, broker may offer member a Lyft RideShare if there are no other types of drivers available and member does not have any medical needs that do not allow member to use a car, bus or taxi to get to appointments. Member cannot request that a Lyft RideShare be used for initial ride requests or any other ride requests. Reimbursement for any Lyft or other RideShare trips (i.e., Lyft, Uber) will not be allowed.

DEFINITIONS

Emergency Medical Condition: A medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the members health in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

AFFECTED DEPARTMENTS/PARTIES

Member Services
Provider Relations
Vendor Management
Grievance & Appeal
Case & Disease Management

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

Physician Certification Statement (PCS) form
Alliance Evidence of Coverage (EOC)

Transportation Template
UM-002 Coordination of Care

REVISION HISTORY

1/1/2008, 10/28/2009, 11/19/2010, 8/30/2012, 1/7/2014, 01/10/2016, 12/15/2016, 8/24/2017, 08/03/2018, 09/06/2018, 11/21/2019, 1/21/21, 5/20/2021, 6/28/2022, 02/21/2023

REFERENCES

AB 2394, Chapter 615, Statutes of 2016California Bridge to Reform Demonstration No. 11-W-00193/9, § 81.f.ix
AB 1642, Wood. Medi-Cal: Managed Care Plans (1)
DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services
APL 17-004 Subcontractual Relationships and Delegation
APL 19-004 Provider Credentialing/Recredentialing and Screening/Enrollment
APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights' Templates
DHCS MCP Contract.
Federal Statute 420.5.C.S 1396b [V])
Medi-Cal Criteria Manual Chapter 12.1
Title 22 CCR, Section 51056(a)
Title 28 CCR, Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)
Title 28 CCR, Section 1300.67(g)(1)

MONITORING

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

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	CM-004
Policy Name	Care Coordination of Services
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal and Group Care
Effective Date	06/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~11/17/2023~~TBD
Compliance Committee Approval Date	~~12/19/2023~~TBD

POLICY STATEMENT

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

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

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

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

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

PROCEDURE

Scope

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

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

Referral Screening

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

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

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

ii. Routine – referral opened within 5 calendar days.

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

Case Manager Role in Care Coordination Case

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

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

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

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

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

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

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

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

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

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

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

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

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

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

r. Ensuring no duplication of services occur

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

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

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

Referral Processing Timeframes

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

Children with Special Health Care Needs (CSHCN)

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

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

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

Direct Observed Therapy for TB

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

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

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

Coordination with IHSS

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

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

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

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

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

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

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

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

Referrals to CCM

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

    A CCM Referral Form is at Attachment 1. However, a referral form is not necessary, and all information can be taken by phone or any other means.
5. Upon receipt of the necessary information for a referral, the CM/DM designated staff shall document the referral in the member's file by entering the information into the referral summary screen in the Clinical Information System. Details on

data entry are described in *CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment*.

1. **Referrals from CCM to CC**

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

DEFINITIONS

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

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

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

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

REVISION HISTORY

CM-004 Care Coordination of Services

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

REFERENCES

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

MONITORING

Referrals to and from CCM are monitored through:

a. Number of referrals to CCM from referral sources.
b. Case files audits for referrals from CCM.
c. Performance against referral timeliness standards

Monitoring for IHSS referrals:

a. Members receiving IHSS will be tracked and coordinating services will continue until IHSS notifies the Alliance that IHSS is no longer needed for the member.

ATTACHMENT 1

ALAMEDA Alliance FOR HEALTH

Case Management (CM) Program Referral Form

Thank you for your interest in referring your Alameda Alliance for Health (Alliance) patient to our Case Management (CM) program.

INSTRUCTIONS

Please return the completed form via mail, email or fax:

Alameda Alliance for Health
ATTN: Case and Disease Management Department (CMDM)
1240 South Loop Road, Alameda, CA 94502
Email: **deptcmdm@alamedaalliance.org**
Fax: **1.510.747.4130**

PLEASE NOTE: The Alliance will directly notify the member which CM program can provide them services. For questions, please contact the Alliance CMDM Department via email or call toll-free at **1.877.251.9612**.

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

Name: _____
Facility/Clinic Name: _____
Phone Number: _____ Fax Number: _____
Referral Source: ☐ Community Partner ☐ Hospital ☐ PCP ☐ Specialty Provider
☐ Other: _____

SECTION 2: PATIENT INFORMATION

Last Name: _____ First Name: _____
Alliance Member ID #: _____ Date of Birth (MM/DD/YYYY): _____
Phone Number: _____ Sex: ☐ Female ☐ Male
Address *(or location i.e. under 5th St. bridge)*: _____
City: _____ State: _____ Zip: _____

SECTION 3: REFERRAL INFORMATION

Referral for (please choose one (1) per referral): ☐ RN ☐ MSW ☐ Health Navigator ☐ Other
Please Note: Health Navigators are able to assist with basic case management services (e.g. DME, appointments).
☐ Patient has been informed of referral.

Reason for referral (*please attach supporting/clinical documents* ***up to the past 30 days***).
For behavioral health referrals, please call Beacon toll-free at **1.855.856.0577**.

Situation/background (including past medical history (PMH), if applicable):

Specific action item request(s):

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

CMDM_PRVDRS_ PROG REF FORM 03/2021

ALAMEDA Alliance FOR HEALTH

Case and Disease Management (CMDM) – Program Referral Form

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

INSTRUCTIONS

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

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

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

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

Name: _____

Facility/Clinic Name: _____

Phone Number: _____ Fax Number: _____

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

☐ Other: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

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

Phone Number: _____ Sex: ☐ Female ☐ Male

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

City: _____ State: _____ Zip: _____

SECTION 3: PROGRAM REFERRAL

Please select one (1) program per referral form:

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

☐ Asthma Disease Management ☐ Depression Disease Management

☐ Cardiovascular Disease Management ☐ Diabetes Disease Management

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

SECTION 4: REASON FOR REFERRAL

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

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

CMDM_PRVDR_FORMS_PROG REF 09/2023

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

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

POLICY STATEMENT

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

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

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

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

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

PROCEDURE

Scope

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

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

Referral Screening

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

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

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

ii. Routine – referral opened within 5 calendar days.

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

Case Manager Role in Care Coordination Case

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

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

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

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

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

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

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

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

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

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

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

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

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

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

r. Ensuring no duplication of services occur

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

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

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

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

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

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

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

Direct Observed Therapy for TB

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

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

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

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

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

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

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

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

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

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

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

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

    A CCM Referral Form is at Attachment 1. However, a referral form is not necessary, and all information can be taken by phone or any other means.
5. Upon receipt of the necessary information for a referral, the CM/DM designated staff shall document the referral in the member's file by entering the information into the referral summary screen in the Clinical Information System. Details on

data entry are described in *CM-001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment*.

1. **Referrals from CCM to CC**

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

DEFINITIONS

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

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

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

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

REVISION HISTORY

CM-004 Care Coordination of Services

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

REFERENCES

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

MONITORING

Referrals to and from CCM are monitored through:

a. Number of referrals to CCM from referral sources.
b. Case files audits for referrals from CCM.
c. Performance against referral timeliness standards

Monitoring for IHSS referrals:

a. Members receiving IHSS will be tracked and coordinating services will continue until IHSS notifies the Alliance that IHSS is no longer needed for the member.

ALAMEDA Alliance FOR HEALTH

Case and Disease Management (CMDM) – Program Referral Form

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

INSTRUCTIONS

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

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

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

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

Name: _____

Facility/Clinic Name: _____

Phone Number: _____ Fax Number: _____

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

☐ Other: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

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

Phone Number: _____ Sex: ☐ Female ☐ Male

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

City: _____ State: _____ Zip: _____

SECTION 3: PROGRAM REFERRAL

Please select one (1) program per referral form:

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

☐ Asthma Disease Management ☐ Depression Disease Management

☐ Cardiovascular Disease Management ☐ Diabetes Disease Management

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

SECTION 4: REASON FOR REFERRAL

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

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

POLICY AND PROCEDURE

Policy Number	CM-005
Policy Name	Disease Management
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	All
Effective Date	06/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~4/19/2024~~TBD
Administrative Oversight Committee Approval Date	~~6/12/2024~~TBD

POLICY STATEMENT

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

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

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

PROCEDURE

Scope

This Policy and Procedure addresses the DM process at the Alliance. DM consists of the following related processes: Identification and Screening; Risk Stratification; Enrollment; Assessment; Care Plan Development and Management; and DM Evaluation and Closure. Referrals ~~in~~to DM are also addressed as part of the Identification process. Definitions of terms used for the DM program are also included within this Policy and Procedure. ~~The Diabetes and Asthma Assessment tools referenced within this Policy and Procedure are configured and accessible within the Clinical Information System.~~

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

DM Identification and Screening

Members are eligible for DM if they have a diagnosis of diabetes, asthma, hypertension or are at risk for perinatal depression ~~and are over 18 years of age or diagnosis of asthma under 19 years of age~~.

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

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

1. Members are identified for program eligibility through one of the following:
    a. Monthly report from HealthCare Analytics department utilizing claims, encounter, and pharmacy data. The report is further risk stratified into low, moderate, or high risk.
    b. Health Risk Assessment (HRA) for Medi-Cal Seniors and Persons with Disability

(SPD). Members are identified as eligible with the appropriate age and diagnoses eligible for the DM program, and have a score, as outlined in the CM-008 SPD HRA Survey and Interventions policy, calculated from HRA answers that may impact the member's health. The list of members meeting these criteria will be provided to the ~~Intake~~ CMDM Department for further processing.

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

Information needed for a DM referral includes:

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

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

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

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

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

DM Risk Stratification

1. ~~The CM/DM designee shall stratify all~~All members who are directly referred to the Alliance DM services are stratified into the appropriate DM program.

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

   a. High Risk Diabetes: Eligible age members with a diagnosis of diabetes ~~and will also meet specific criteria for Complex Case Management with case management nurse and or pharmacy interventions and receive more intensive care, as well as have opportunities to receive health education and care coordination.~~ whose A1c is over 9.0, and has increased health services utilization over the past 12 months

   ~~a.~~

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

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

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

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

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

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

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

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

4. The CM/DM designee will process referrals within the following time frames:

   a. Urgent – referral opened within 1 business day.

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b. Routine – referral opened within 5 business days.

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

Enrollment

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

Risk Assessment

1. Members who chose to engage in the DM programs will be assessed using an appropriate assessment within the Clinical Information System. Procedures for conducting assessments are addressed in *CM-001, Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment*.
2. Supports will be assigned depending on their risk stratification, needs and interest.
   - Health Navigation
   - Health Education/Coaching
   - Social Work
   - Medication reconciliation/education – Pharmacy
   - Nurse Case Management
   - Behavioral health care management

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

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

DM Plan Development and Management

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

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

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

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

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

DM Case Evaluation and Closure

1. The DM program is structured where DM cases are closed either by meeting

prescribed length in program criteria or by defined closure criteria.

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

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

~~4. Medium Risk Diabetes Program enrollees will be considered disenrolled at the time a new DM Low Risk report is provided.~~ If the member is no longer identified as ~~having gaps in care~~needing disease management supports, ~~he/she~~they will no longer be in the program.

~~5.~~3. All closure actions will be documented in the Care Plan as applicable and in the Program Enrollment section of Clinical Information System. ~~System except for Low Risk Program enrollees who will be considered automatically disenrolled as described above~~.

~~6.~~4. At the time of case closure, a satisfaction survey and a case closure letter, if appropriate, will be sent.

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DEFINITIONS

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

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

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

DM Assessment Process: Assessment is a process of compiling data including claims and medication history, HRA data and member questions to provide the basis to analyze services needed and to assist in identifying care gaps or creating a care plan. ~~The Alliance uses a High Risk Diabetes and a High Risk Asthma Specialty Assessment and a Moderate Risk Diabetes Assessment in their DM program.~~

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

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

DM Intervention: An intervention is an action that increases the probability that a desired outcome will occur.

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

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

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

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

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

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

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

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CM -001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
CM-002, Policy and Procedure, Complex Case Management (CCM) Plan Development and Management
CM-003, Policy and Procedure, Complex Case Management Plan Evaluation and Closure
DM Program Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment 1. DM Referral Action – Desk Reference

REVISION HISTORY

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

REFERENCES

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

MONITORING

The DM program is monitored through:

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

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~~ATTACHMENT 1~~

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ALAMEDA Alliance FOR HEALTH

Case Management (CM) Program Referral Form

Thank you for your interest in referring your Alameda Alliance for Health (Alliance) patient to our Case Management (CM) program.

INSTRUCTIONS

Please return the completed form via mail, email or fax:

Alameda Alliance for Health
ATTN: Case and Disease Management Department (CMDM)
1240 South Loop Road, Alameda, CA 94502
Email: **deptcmdm@alamedaalliance.org**
Fax: **1.510.747.4130**

PLEASE NOTE: The Alliance will directly notify the member which CM program can provide them services. For questions, please contact the Alliance CMDM Department via email or call toll-free at **1.877.251.9612**.

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

Name: _____

Facility/Clinic Name: _____

Phone Number: _____ Fax Number: _____

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

SECTION 2: PATIENT INFORMATION

Last Name: _____ First Name: _____

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

Phone Number: _____ Sex: ☐ Female ☐ Male

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

City: _____ State: _____ Zip: _____

SECTION 3: REFERRAL INFORMATION

Referral for (please choose one (1) per referral): ☐ RN ☐ MSW ☐ Health Navigator ☐ Other

Please Note: Health Navigators are able to assist with basic case management services (e.g. DME, appointments).

☐ Patient has been informed of referral.

Reason for referral (*please attach supporting/clinical documents **up to the past 30 days***).
For behavioral health referrals, please call Beacon toll-free at **1.855.856.0577**.

Situation/background (including past medical history (PMH), if applicable):

Specific action item request(s):

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

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ALAMEDA Alliance FOR HEALTH

Case and Disease Management (CMDM) – Program Referral Form

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

INSTRUCTIONS

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

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

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

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

Name: _____

Facility/Clinic Name: _____

Phone Number: _____ Fax Number: _____

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

☐ Other: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

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

Phone Number: _____ Sex: ☐ Female ☐ Male

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

City: _____ State: _____ Zip: _____

SECTION 3: PROGRAM REFERRAL

Please select one (1) program per referral form:

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

☐ Asthma Disease Management ☐ Depression Disease Management

☐ Cardiovascular Disease Management ☐ Diabetes Disease Management

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

SECTION 4: REASON FOR REFERRAL

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

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

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

POLICY AND PROCEDURE

Policy Number	CM-005
Policy Name	Disease Management
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Lines of Business	All
Effective Date	06/01/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

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

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

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

PROCEDURE

Scope

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

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

DM Identification and Screening

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

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

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

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

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

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

Information needed for a DM referral includes:

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

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

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

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

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

DM Risk Stratification

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

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

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

months

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

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

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

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

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

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

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

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

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

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

Enrollment

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

Risk Assessment

1. Members who chose to engage in the DM programs will be assessed using an appropriate assessment within the Clinical Information System. Procedures for conducting assessments are addressed in *CM-001, Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment*.
2. Supports will be assigned depending on their risk stratification, needs and interest.
    - Health Navigation
    - Health Education/Coaching
    - Social Work
    - Medication reconciliation/education – Pharmacy
    - Nurse Case Management
    - Behavioral health care management

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

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

DM Plan Development and Management

1. The procedures described in *CM-002, Complex Case Management (CCM) Plan*

Development and Management, apply to the development of a DM Care Plan. As described in that policy, the steps in developing the Care Plan involve:

a. Development of case management goals, including prioritized goals
b. Identification of barriers to meet the goals and complying with the plans
c. Development of schedules for follow-up and communication with members
d. Development and communication of member self-management plans
e. Assessment of progress against care plans and goals, and modifications as needed

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

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

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

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

DM Case Evaluation and Closure

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

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

DM Program enrollees will also be evaluated for closure to DM services using CM-003 *Policy and Procedure, Complex Case Management (CCM) Plan Evaluation and Closure*. However, the length of time in the program should not exceed 6 months of participation in the program. If the member is no longer identified as needing disease management supports, they will no longer be in the program.

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

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

DEFINITIONS

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

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

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

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

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

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

DM Intervention: An intervention is an action that increases the probability that a desired outcome will occur.

Active Member Participation Rate: Number of members who have received at least one

interactive contact in an intervention, divided by the number of members who are identified as eligible for the program.

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

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

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

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

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

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

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CM -001 Policy and Procedure, Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
CM-002, Policy and Procedure, Complex Case Management (CCM) Plan Development and Management
CM-003, Policy and Procedure, Complex Case Management Plan Evaluation and

Closure DM Program Description

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment 1. DM Referral Action – Desk Reference

REVISION HISTORY

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

REFERENCES

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

MONITORING

The DM program is monitored through:

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

ALAMEDA Alliance FOR HEALTH

Case and Disease Management (CMDM) – Program Referral Form

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

INSTRUCTIONS

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

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

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

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

Name: _____

Facility/Clinic Name: _____

Phone Number: _____ Fax Number: _____

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

☐ Other: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

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

Phone Number: _____ Sex: ☐ Female ☐ Male

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

City: _____ State: _____ Zip: _____

SECTION 3: PROGRAM REFERRAL

Please select one (1) program per referral form:

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

☐ Asthma Disease Management ☐ Depression Disease Management

☐ Cardiovascular Disease Management ☐ Diabetes Disease Management

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

SECTION 4: REASON FOR REFERRAL

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

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

h.

POLICY AND PROCEDURE

Policy Number	CM-008
Policy Name	SPD HRA – Survey and Interventions
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal, Group Care
Effective Date	1/1/2018
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	~~8/18/2023~~TBD
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

OVERVIEW

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

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

The assessment is conducted in a manner that promotes full sharing of information in an engaging environment of trust and in a culturally and linguistically appropriate manner.

POLICY

The Alliance performs a Health Risk Assessment (HRA) survey, which includes a Health Information Form/Member Evaluation Tool (HIF/MET) within the required timeframe for the

purposes of developing individualized care plans for members as follows:

a. Within 45 days of enrollment for those initially stratified as higher risk per CM-007 SPD High Risk Stratification.

b. Within 105 days of enrollment for those initially stratified as lower risk per CM-007 SPD High Risk Stratification.

The HRA includes specific Long-Term Services and Supports (LTSS) referral questions intended to assist in identifying members who may qualify or benefit from LTSS services. These questions are for referral purposes only and are not meant to be used in classifying high and low risk members. After completion of the HRA, the Alliance develops an Individualized Care Plan (ICP) for members and coordinates referrals, including referrals for LTSS, as needed.

If a SPD member disenrolls from the Alliance, the Plan will make the results of the HIF/MET available to the new Managed Care Plan upon request.

PROCEDURE

1. Development of the HRA questions
   1) At the initial time of the HRA development the Alliance Health Care Analytics Department will work with the Compliance Department and the ~~Member~~ Community Advisory Committee (~~MAC~~CAC) to provide input into the development of the HRA questions pertinent to the membership.
   2) Long Term Services and Supports (LTSS) questions in the HRA are mandated and must be used verbatim.
   3) Any changes to the HRA will be approved internally at the Utilization Management Sub-Committee meeting and subsequently through the Health Care Quality Committee meeting.
   4) Updates to the HRA go through a formal approval process from the Department of HealthCare Services (DHCS) before changes are implemented.
   5) The Alliance Case Management/HRA Clinic Team is responsible for ensuring the appropriate questions are developed and weighted appropriate to identify member's needs.

2. The Alliance HRA has specific questions to:
   A. identify a member's need for help in facilitating timely access to primary care, specialty care, DME, medications, and other health services,
   B. identify the referrals a member needs to appropriate community resources and other agencies for services outside of the Alliance's scope of responsibility
   C. identify a member's need for and appropriate level of involvement of caregivers
   D. identify a member's need for help in facilitating communication among the member's health care providers,
   E. identify a member's need for other activities or services that would help the member to optimize his or her health status
   F. identify a member's need for coordination of care across all settings, including those outside the Alliance's provider network;
   G. ensure that a member admitted to a hospital or institution receives appropriate discharge planning;

and

H. ensure the standardized LTSS referral questions are used to refer members who may qualify for and benefit from LTSS services.

3. Each HRA Survey includes HIF/MET questions. Per APL 17-013 HIF/MET process, the HRA process will include:
   A. A process to include the HIF/MET questions in each newly enrolled SPD member's HRA survey, mailed to them upon enrollment and annually thereafter including a postage paid envelope for mailing back the completed form;
   B. Within 90 days of each new SPD member's date of enrollment, at least two telephone call attempts will be made to remind new SPD member to return the HRA survey and/or collect the HRA with HIF/MET information from new SPD members;
   C. When the HRA survey is completed o returned, within 90 days of enrollment for each SPD member, the Alliance will utilize the information to complete a screening of each new SPD member's needs.
   D. A process, upon an SPD member's disenrollment, to make any HIF/MET assessment results available to the SPD member's new MCP upon request.

4. Two Telephone Call Attempts
   A. Low Risk Members: The Alliance sends a data file including all annual and new, non-SPD members that have been stratified as low risk as per CM-007 to the internal IT department to complete two call attempts, one week apart, within 90 days of enrollment or their annual anniversary.
      1) The IT department uses the Alliance Member Services phone number as the Caller ID and members are provided Member Services phone number to call if they have questions.
      2) Member Services will assist any member in completing the HRA survey if they call and request assistance.
   B. High Risk Members: Data Analytics will send a monthly list of members that have been stratified as high risk as per CM-007 to Case Management to complete phone call outreach attempts. Case Management staff will call the member twice in an attempt to remind or assist the member in completing their HRA survey. If the first call attempt is successful, there will be a second call attempt if the HRA survey is not received within 1 month of the first call. Each call attempt is entered into the existing Clinical Information System.

5. Scoring of HRA Surveys
   A. The responses to the HRA survey, which includes HIF/MET questions, are input into the existing Clinical Information System and are used in the re-stratification of the member's health and care needs.
      1) The HRA questions are designed to identify certain risk factors for each patient. At the end of the assessment process, based on responses to questions, the existing Clinical Information System automatically re-stratifies and assigns a new risk stratification score.
      2) Scoring methodology: See attachment
      3) Combinations of questions and responses are used to stratify the risk of each member in the following categories:
         a) High Risk: member receives a score of 9 or greater on their Health Risk

Assessment Survey.

b) Low Risk: member receives a score of 8 or less on their Health Risk Assessment Survey.

B. For some members, the re-classification based on answers to the HRA survey may be different from their earlier classification based on the initial stratification method.

C. The CM staff will identify any SPD members who may not have been identified initially as high risk due to the lack of data and will re-classify them as high risk.

6. Care Plan Development and Mailing

A. For members identified as low risk through their responses to the HRA survey, regardless of their risk level at initial stratification, or who do not complete their HRA survey, a system generated care plan is developed. The care plan populates with education resources based on preventive health reminders. The care plan includes information encouraging members to schedule an appointment with their assigned primary care provider for ongoing care needs.

B. A copy of the care plan is sent to the member along with educational resources.

C. A copy of the care plan is sent to the primary care provider.

1) For members without an assigned primary care provider at the time of mailing, the member information will be sent to the Case Management Department to assess next steps.

D. Members identified as high risk through their responses to the HRA survey, regardless of their risk level at initial stratification, are assigned to an Alliance Nurse CM for Care Plan development.

1) Care plans are generated by Case Managers based on the HRA responses and other available clinical information. An individualized care plan is developed in collaboration with the member and/or the member's caregiver. The care planning process is per CM-002 Complex Case Management Plan Development and Management.

2) Case Managers assigned a high-risk member may revise the member's risk category after assessing the member's needs and determining the member does not meet the criteria for high risk.

7. High Risk Care Planning and Interventions

A. The care plan contains the following components:

1) Appropriate involvement of caregivers

a) The assessment will include process for identifying a member's need for and appropriate level of involvement of caregivers interventions with identified problem and goals are placed into the care plan from a database pool of interventions. Through conversations with CM staff and/or Alliance staff and/or providers, members and caregivers can add interventions and or make customizations to existing interventions.

2) Facilitating timely access to primary care, specialty care, durable medical equipment, medications, mental health and substance abuse providers or other health services including any physical or cognitive services. The need for referrals to resolve any physical or cognitive barriers to access will also be assessed.

3) Services needed to assist members in optimizing their health status, including assisting with self-management skills or techniques and health education.
4) Coordinated care across all settings including those outside the provider network
    a) Regardless of risk level, the plan's Case Manager, Member Service Unit and the PCP share a common responsibility for coordination of care across multiple settings, including those outside of the medical network. The CM/DM staff and Member Services representative staff are trained to assist members with issues that involve accessing community resources, including but not limited to food insecurity, SSI and other social services questions, behavioral health, housing and support groups for various conditions and needs.
    b) The care plan is shared across the appropriate entities (i.e. PCPs, mental health provider, etc.) who may serve the member. At each encounter, the responsible entity reviews the member's care plan with the member or their authorized representative to validate if the member has any unmet needs or additional needs for other types of services.
5) Referrals to appropriate community resources and other agencies for services outside the scope of responsibility of the managed care health plan including but not limited to mental health and behavioral health, personal care, housing, home-delivered meals, energy assistance programs and services for the intellectual and developmental disabilities.

B. Referrals to Long Term Support Services
1) Using the standardized questions from the HRA, the Alliance staff will identify members who qualify for or who could benefit from LTSS.
2) The Alliance maintains a listing of community resources, Long-Term Services and Supports (LTSS) and health education resources. This resource listing and health education directory are updated as new resources are identified and older ones become invalid.
3) Both the Alliance and its contracted Provider Groups may identify and refer members for LTSS services.

C. Interventions may be developed specific to the required care management of high risk members. The interventions are grouped into the following eight categories:
1) Complex Case Management
2) Physician Services
3) Medication Management
4) Behavioral, Mental & Cognitive Health
5) Nutrition
6) Education
7) Advance Care Planning
8) Daily Activity Management

D. Care Plan process will follow the procedure as outlined in CM-002 Complex Case Plan Development and Management.

8. Effectiveness of the HRA assessment
A. Annually, the Health Care Analytics Department and Medical Services Department review the HRA to ensure the tool is identifying members appropriately for the various stratification levels.

B. Results of the report are presented to the UM Sub-Committee and, when necessary, Health Care Quality Committee.

9. Oversight
   A. The Alliance will monitor compliance through analysis of routine reporting.
   B. Quarterly reports will be reported to the Utilization Management Sub-Committee and subsequently to the Health Care Quality Committee (HCQC).

DEFINITIONS/ACRONYMS

Health Information Form (HIF)/Member Evaluation Tool (MET): The information collected from a health information form and completed by members at the time of enrollment by which members may self-identify disabilities, acute and chronic health conditions and transitional service needs.
Health Risk Assessment Risk Stratification: Mechanism or algorithm designed for identify newly enrolled members

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

Lower Risk: MediCal members who need basic care management.

CAC: Community Advisory Committee

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This classification methodology is consistent with the guidelines defined in Department of Health Care Services (DHCS) All Plan Letter: 17-013 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities.

AFFECTED DEPARTMENTS/PARTIES

Case Management
Health Care Analytics
Member Services
Utilization
Management
Quality Improvement

RELATED POLICIES AND PROCEDURES

CM-001 Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
CM-002 Complex Case Management Plan Development and Management
CM-003 Complex Case Management Plan Evaluation and Closure
UM-002 Coordination of Care
CM-007 SPD Health Risk Initial Stratification

RELATED WORKFLOW DOCUMENTS OR OTHER

ATTACHMENTS

Health Information Form/Member Evaluation Tool (HIF/MET)
HRA Scoring Methodology

REVISION HISTORY

1/4/2018, 11/15/18, 4/16/19, 04/24/2020, 11/23/2021, 03/22/2022, 9/19/2023

REFERENCES

DHCS Contract, Exhibit A, Attachment 10
DHCS All Plan Letter17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities
Welfare & Institutions Code § 14182

MONITORING

The Compliance and Utilization Management Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Health Care Quality Committee (HCQC) annually for review and approval.

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

POLICY AND PROCEDURE

Policy Number	CM-008
Policy Name	SPD HRA – Survey and Interventions
Department Name	Case and Disease Management
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal, Group Care
Effective Date	1/1/2018
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

OVERVIEW

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The assessment is conducted in a manner that promotes full sharing of information in an engaging environment of trust and in a culturally and linguistically appropriate manner.

POLICY

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purposes of developing individualized care plans for members as follows:

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If a SPD member disenrolls from the Alliance, the Plan will make the results of the HIF/MET available to the new Managed Care Plan upon request.

PROCEDURE

1. Development of the HRA questions
   1) At the initial time of the HRA development the Alliance Health Care Analytics Department will work with the Compliance Department and the Community Advisory Committee (CAC) to provide input into the development of the HRA questions pertinent to the membership.
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   A. identify a member's need for help in facilitating timely access to primary care, specialty care, DME, medications, and other health services,
   B. identify the referrals a member needs to appropriate community resources and other agencies for services outside of the Alliance's scope of responsibility
   C. identify a member's need for and appropriate level of involvement of caregivers
   D. identify a member's need for help in facilitating communication among the member's health care providers,
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   F. identify a member's need for coordination of care across all settings, including those outside the Alliance's provider network;
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and

H. ensure the standardized LTSS referral questions are used to refer members who may qualify for and benefit from LTSS services.

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   A. A process to include the HIF/MET questions in each newly enrolled SPD member's HRA survey, mailed to them upon enrollment and annually thereafter including a postage paid envelope for mailing back the completed form;
   B. Within 90 days of each new SPD member's date of enrollment, at least two telephone call attempts will be made to remind new SPD member to return the HRA survey and/or collect the HRA with HIF/MET information from new SPD members;
   C. When the HRA survey is completed o returned, within 90 days of enrollment for each SPD member, the Alliance will utilize the information to complete a screening of each new SPD member's needs.
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4. Two Telephone Call Attempts
   A. Low Risk Members: The Alliance sends a data file including all annual and new, non-SPD members that have been stratified as low risk as per CM-007 to the internal IT department to complete two call attempts, one week apart, within 90 days of enrollment or their annual anniversary.
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   B. High Risk Members: Data Analytics will send a monthly list of members that have been stratified as high risk as per CM-007 to Case Management to complete phone call outreach attempts. Case Management staff will call the member twice in an attempt to remind or assist the member in completing their HRA survey. If the first call attempt is successful, there will be a second call attempt if the HRA survey is not received within 1 month of the first call. Each call attempt is entered into the existing Clinical Information System.

5. Scoring of HRA Surveys
   A. The responses to the HRA survey, which includes HIF/MET questions, are input into the existing Clinical Information System and are used in the re-stratification of the member's health and care needs.
      1) The HRA questions are designed to identify certain risk factors for each patient. At the end of the assessment process, based on responses to questions, the existing Clinical Information System automatically re-stratifies and assigns a new risk stratification score.
      2) Scoring methodology: See attachment
      3) Combinations of questions and responses are used to stratify the risk of each member in the following categories:
         a) High Risk: member receives a score of 9 or greater on their Health Risk

Assessment Survey.

b) Low Risk: member receives a score of 8 or less on their Health Risk Assessment Survey.

B. For some members, the re-classification based on answers to the HRA survey may be different from their earlier classification based on the initial stratification method.

C. The CM staff will identify any SPD members who may not have been identified initially as high risk due to the lack of data and will re-classify them as high risk.

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B. A copy of the care plan is sent to the member along with educational resources.

C. A copy of the care plan is sent to the primary care provider.

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1) Care plans are generated by Case Managers based on the HRA responses and other available clinical information. An individualized care plan is developed in collaboration with the member and/or the member's caregiver. The care planning process is per CM-002 Complex Case Management Plan Development and Management.

2) Case Managers assigned a high-risk member may revise the member's risk category after assessing the member's needs and determining the member does not meet the criteria for high risk.

7. High Risk Care Planning and Interventions

A. The care plan contains the following components:

1) Appropriate involvement of caregivers

a) The assessment will include process for identifying a member's need for and appropriate level of involvement of caregivers interventions with identified problem and goals are placed into the care plan from a database pool of interventions. Through conversations with CM staff and/or Alliance staff and/or providers, members and caregivers can add interventions and or make customizations to existing interventions.

2) Facilitating timely access to primary care, specialty care, durable medical equipment, medications, mental health and substance abuse providers or other health services including any physical or cognitive services. The need for referrals to resolve any physical or cognitive barriers to access will also be assessed.

3) Services needed to assist members in optimizing their health status, including assisting with self-management skills or techniques and health education.
4) Coordinated care across all settings including those outside the provider network
    a) Regardless of risk level, the plan's Case Manager, Member Service Unit and the PCP share a common responsibility for coordination of care across multiple settings, including those outside of the medical network. The CM/DM staff and Member Services representative staff are trained to assist members with issues that involve accessing community resources, including but not limited to food insecurity, SSI and other social services questions, behavioral health, housing and support groups for various conditions and needs.
    b) The care plan is shared across the appropriate entities (i.e. PCPs, mental health provider, etc.) who may serve the member. At each encounter, the responsible entity reviews the member's care plan with the member or their authorized representative to validate if the member has any unmet needs or additional needs for other types of services.
5) Referrals to appropriate community resources and other agencies for services outside the scope of responsibility of the managed care health plan including but not limited to mental health and behavioral health, personal care, housing, home-delivered meals, energy assistance programs and services for the intellectual and developmental disabilities.

B. Referrals to Long Term Support Services
1) Using the standardized questions from the HRA, the Alliance staff will identify members who qualify for or who could benefit from LTSS.
2) The Alliance maintains a listing of community resources, Long-Term Services and Supports (LTSS) and health education resources. This resource listing and health education directory are updated as new resources are identified and older ones become invalid.
3) Both the Alliance and its contracted Provider Groups may identify and refer members for LTSS services.

C. Interventions may be developed specific to the required care management of high risk members. The interventions are grouped into the following eight categories:
1) Complex Case Management
2) Physician Services
3) Medication Management
4) Behavioral, Mental & Cognitive Health
5) Nutrition
6) Education
7) Advance Care Planning
8) Daily Activity Management

D. Care Plan process will follow the procedure as outlined in CM-002 Complex Case Plan Development and Management.

8. Effectiveness of the HRA assessment
A. Annually, the Health Care Analytics Department and Medical Services Department review the HRA to ensure the tool is identifying members appropriately for the various stratification levels.

B. Results of the report are presented to the UM Sub-Committee and, when necessary, Health Care Quality Committee.

9. Oversight
   A. The Alliance will monitor compliance through analysis of routine reporting.
   B. Quarterly reports will be reported to the Utilization Management Sub-Committee and subsequently to the Health Care Quality Committee (HCQC).

DEFINITIONS/ACRONYMS

Health Information Form (HIF)/Member Evaluation Tool (MET): The information collected from a health information form and completed by members at the time of enrollment by which members may self-identify disabilities, acute and chronic health conditions and transitional service needs.

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

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

Lower Risk: MediCal members who need basic care management.

CAC: Community Advisory Committee

This classification methodology is consistent with the guidelines defined in Department of Health Care Services (DHCS) All Plan Letter: 17-013 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities.

AFFECTED DEPARTMENTS/PARTIES

Case Management
Health Care Analytics
Member Services
Utilization
Management
Quality Improvement

RELATED POLICIES AND PROCEDURES

CM-001 Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment
CM-002 Complex Case Management Plan Development and Management
CM-003 Complex Case Management Plan Evaluation and Closure
UM-002 Coordination of Care
CM-007 SPD Health Risk Initial Stratification

RELATED WORKFLOW DOCUMENTS OR OTHER

ATTACHMENTS

Health Information Form/Member Evaluation Tool (HIF/MET)
HRA Scoring Methodology

REVISION HISTORY

1/4/2018, 11/15/18, 4/16/19, 04/24/2020, 11/23/2021, 03/22/2022, 9/19/2023

REFERENCES

DHCS Contract, Exhibit A, Attachment 10
DHCS All Plan Letter17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities
Welfare & Institutions Code § 14182

MONITORING

The Compliance and Utilization Management Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Health Care Quality Committee (HCQC) annually for review and approval.

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POLICY AND PROCEDURE

Policy Number	CM-020
Policy Name	Health Information Form/Member Evaluation Tool (HIF/MET)
Department Name	Healthcare Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal
Effective Date	12/17/2015
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	~~5/19/2023~~TBD
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

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

PROCEDURE

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

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

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

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

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

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

Data Sharing

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

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

DEFINITIONS / ACRONYMS

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

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

AFFECTED DEPARTMENTS/PARTIES

Case and Disease Management

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

DHCS Approved HIF/MET Survey Form

REVISION HISTORY

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

REFERENCES

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

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	CM-020
Policy Name	Health Information Form/Member Evaluation Tool (HIF/MET)
Department Name	Healthcare Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal
Effective Date	12/17/2015
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

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

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

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

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

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

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DEFINITIONS / ACRONYMS

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

AFFECTED DEPARTMENTS/PARTIES

Case and Disease Management

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

DHCS Approved HIF/MET Survey Form

REVISION HISTORY

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

REFERENCES

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

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	~~CM-021~~CS-005
Policy Name	Community Supports – Asthma Remediation
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/16/2024~~TBD
Compliance Committee Approval Date	~~3/19/2024~~TBD

POLICY STATEMENT

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

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

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

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

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

1.5 Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;

- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;

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

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

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

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

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

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

PROCEDURE

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

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

2.1.2 Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters; and

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

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

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

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

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

2.3 Member Identification.

2.3.1 Referral Based CS

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

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

2.3.1.3 Notification of Eligibility

Members are notified of Asthma Remediation eligibility via written communication.

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

2.4 Referral Based CS

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

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

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

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

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

2.6 Continuity of Care

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

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

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

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

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

2.7 Member Request for Asthma Remediation Services

2.7.1 AAH verifies a member's health plan

2.7.1.1 Request is reviewed

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

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

2.7.2 CS services are voluntary and member can agree or choose not to receive the

services without having any impact on their other services or benefits.

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

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

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

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

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

2.8 Data Sharing

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

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

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

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

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

2.9 Payment

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

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

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

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

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

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

2.10 Restrictions and Limitations

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

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

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

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

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

2.10.1.5 Asthma Remediation modifications are limited to those that are of

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

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

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

2.11 Discontinuing Services

2.11.1 Discontinuing of CS services will be based on:

2.11.1.1 Goals met/improved health status

2.11.1.2 Termination of coverage

2.11.1.3 Unable to establish or maintain contact with a member

2.11.1.4 No longer meets criteria

2.11.1.5 Member/caregiver declines services

2.11.1.6 Death of member

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

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

2.12 Licensing / Allowable Providers

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

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

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

2.12.4 AAH will apply minimum standards to ensure adequate experience and

acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above

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

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

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

DEFINITIONS / ACRONYMS

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

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CRE-018 Assessment of Community Supports Organizational Providers
UM-036 Continuity of Care

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/28/2022, 01/11/2023, 3/19/2024

REFERENCES

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

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POLICY AND PROCEDURE

Policy Number	CS-005
Policy Name	Community Supports – Asthma Remediation
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

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

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

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

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

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

1.5 Examples of environmental asthma trigger remediations include:

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- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;

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

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

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

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PROCEDURE

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

2.1.2 Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters; and

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

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

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

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

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

2.3 Member Identification.

2.3.1 Referral Based CS

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

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

2.3.1.3 Notification of Eligibility

Members are notified of Asthma Remediation eligibility via written communication.

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

2.4 Referral Based CS

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

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

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

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

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

2.6 Continuity of Care

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

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

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

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

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

2.7 Member Request for Asthma Remediation Services

2.7.1 AAH verifies a member's health plan

2.7.1.1 Request is reviewed

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

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

2.7.2 CS services are voluntary and member can agree or choose not to receive the

services without having any impact on their other services or benefits.

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

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

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

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

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

2.8 Data Sharing

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

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

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

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

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

2.9 Payment

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

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

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

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

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

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

2.10 Restrictions and Limitations

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

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

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

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

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

2.10.1.5 Asthma Remediation modifications are limited to those that are of

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

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

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

2.11 Discontinuing Services

2.11.1 Discontinuing of CS services will be based on:

2.11.1.1 Goals met/improved health status

2.11.1.2 Termination of coverage

2.11.1.3 Unable to establish or maintain contact with a member

2.11.1.4 No longer meets criteria

2.11.1.5 Member/caregiver declines services

2.11.1.6 Death of member

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

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

2.12 Licensing / Allowable Providers

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

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

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

2.12.4 AAH will apply minimum standards to ensure adequate experience and

acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above

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

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

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

DEFINITIONS / ACRONYMS

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

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CRE-018 Assessment of Community Supports Organizational Providers
UM-036 Continuity of Care

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/28/2022, 01/11/2023, 3/19/2024

REFERENCES

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

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

POLICY AND PROCEDURE

Policy Number	~~CM-022~~CS-003
Policy Name	Community Supports – Housing Deposits
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/16/2024~~TBD
Compliance Committee Approval Date	~~3/19/2024~~TBD

POLICY STATEMENT

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

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

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Housing Deposits Services for their CS clients experiencing homelessness and housing instability.

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

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

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support

recruitment of providers who can meet the cultural, language, age and disability needs of our members.

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

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

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

1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.

PROCEDURE

2.1 AAH Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

2.1.1 Security deposits required to obtain a lease on an apartment or home.

2.1.2 Set-up fees and/or deposits for utilities or service access and utility arrearages.

2.1.3 First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

2.1.4 First month and last month's rent as required by landlord for occupancy.

2.1.5 Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

2.1.6 Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

2.2 Housing Deposit services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

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

Housing Deposit Services will not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

2.4 Member Identification

2.4.1 Report Based CS

2.4.1.1 Monthly, the Analytics department runs a Population Report, using data for all members using the specific Housing criteria to identify members.

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

2.4.1.3 Notification of Eligibility
Members are notified of Housing eligibility via written communication.
If not address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all process in the system of record.

2.5 Referrals Based CS

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

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

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

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

2.6 Request for Housing Deposit Services

2.6.1 Once AAH verifies a member's health plan eligibility.

2.6.1.1 Request is reviewed

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

2.6.1.3 Member and provider are notified in accordance with UM

Policy, UM-057, Authorization Service Request.

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

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

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

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

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

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

2.7 Continuity of Care

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

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

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

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

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

2.8 Data Sharing

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

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

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

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

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

2.9 Eligibility

2.7.1 Any AAH member who received Housing Transition/Navigation Services CS in Alameda County.

2.7.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.7.3 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.7.4 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.7.4.1 In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes

of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.7.4.2 By the Department of Housing and Urban Development (HUD) in 24 CFR

91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.7.4.2.1 A 'homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.7.4.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.7.4.2.1.2 Has been homeless and living as described in paragraph (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.7.4.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph of this definition, before entering that facility; or

2.7.4.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.7.5 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.7.5.1 (1) An individual or family who:

2.7.5.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.7.5.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

2.7.5.1.2.1 Meets one of the following conditions:

2.7.5.1.2.1.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.7.5.1.2.1.2 Is living in the home of another because of economic hardship;

2.7.5.1.2.1.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.7.5.1.2.1.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.7.5.1.2.1.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.7.5.1.2.1.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.7.5.1.2.1.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.7.5.2 (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.7.5.3 (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.7.6 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.7.6.1 Have one or more serious chronic conditions;

2.7.6.2 Have a Serious Mental Illness;

2.7.6.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.7.6.4 Have a Serious Emotional Disturbance (children and adolescents);

2.7.6.5 Are receiving Enhanced Care Management; or

2.7.6.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.8 Payment

2.8.1 AAH receives payment from DHCS and disperses funds in a timely manner to CS Providers through collection and submission of data by the CS Provider, and through the contractual agreement made between AAH and the CS Provider.

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

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

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

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

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

2.9 Restrictions and Limitations

2.9.1 Community Supports (CS) are alternative services to covered benefits under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. In lieu of service can only be covered by AAH if:

2.9.1.1 The State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service;

2.9.1.2 Beneficiaries are not required to use the in lieu of service; and

2.9.1.3 The in lieu of service is authorized and identified in the AAH plan contracts.

2.9.2 Housing Deposits will be available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. AAH will make a good faith effort to review information available to them to determine if individual has previously received services.

2.9.3 These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.

2.9.4 Individuals will also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

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

2.10 Discontinuing Services

2.10.1 Discontinuing of CS services will be based on:

2.10.1.1 Meeting the lifetime maximum financial limitation

2.10.1.2 Goals met/completion of housing deposit

2.10.1.3 No longer meets criteria

2.10.1.4 Member/caregiver declines services

2.10.1.5 Death of member

2.10.2 CS provider will submit weekly reports identifying AAH members who have completed the CS service.

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

2.11 Licensing and Allowable Providers

2.11.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.11.2 The entity that is coordinating an individual's Housing Transition Navigation Services, or AAH's case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

2.11.3 AAH will ensure CS Providers have demonstrated or verifiable experience and expertise with providing these unique services.

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

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

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HCSA	Health Care Services Agency

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REVISION HISTORY

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REFERENCES

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MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

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

POLICY AND PROCEDURE

Policy Number	CS-003
Policy Name	Community Supports – Housing Deposits
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	Medi-Cal
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

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

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

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Housing Deposits Services for their CS clients experiencing homelessness and housing instability.

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

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

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support

recruitment of providers who can meet the cultural, language, age and disability needs of our members.

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

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

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

1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.

PROCEDURE

2.1 AAH Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

2.1.1 Security deposits required to obtain a lease on an apartment or home.

2.1.2 Set-up fees and/or deposits for utilities or service access and utility arrearages.

2.1.3 First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

2.1.4 First month and last month's rent as required by landlord for occupancy.

2.1.5 Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

2.1.6 Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

2.2 Housing Deposit services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

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

Housing Deposit Services will not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

2.4 Member Identification

2.4.1 Report Based CS

2.4.1.1 Monthly, the Analytics department runs a Population Report, using data for all members using the specific Housing criteria to identify members.

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

2.4.1.3 Notification of Eligibility
Members are notified of Housing eligibility via written communication.
If not address is present in the Population Report, the member is notified by telephone. The Community Supports team will make two (2) phone call attempts to reach the member. Documenting all process in the system of record.

2.5 Referrals Based CS

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

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

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

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

2.6 Request for Housing Deposit Services

2.6.1 Once AAH verifies a member's health plan eligibility.

2.6.1.1 Request is reviewed

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

2.6.1.3 Member and provider are notified in accordance with UM

Policy, UM-057, Authorization Service Request.

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

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

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

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

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

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

2.7 Continuity of Care

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

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

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

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

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

2.8 Data Sharing

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

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

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

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

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

2.9 Eligibility

2.7.1 Any AAH member who received Housing Transition/Navigation Services CS in Alameda County.

2.7.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.7.3 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.7.4 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.7.4.1 In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes

of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.7.4.2 By the Department of Housing and Urban Development (HUD) in 24 CFR

91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.7.4.2.1 A 'homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.7.4.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.7.4.2.1.2 Has been homeless and living as described in paragraph (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.7.4.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph of this definition, before entering that facility; or

2.7.4.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.7.5 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.7.5.1 (1) An individual or family who:

2.7.5.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.7.5.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

2.7.5.1.2.1 Meets one of the following conditions:

2.7.5.1.2.1.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.7.5.1.2.1.2 Is living in the home of another because of economic hardship;

2.7.5.1.2.1.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.7.5.1.2.1.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.7.5.1.2.1.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.7.5.1.2.1.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.7.5.1.2.1.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.7.5.2 (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.7.5.3 (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.7.6 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.7.6.1 Have one or more serious chronic conditions;

2.7.6.2 Have a Serious Mental Illness;

2.7.6.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.7.6.4 Have a Serious Emotional Disturbance (children and adolescents);

2.7.6.5 Are receiving Enhanced Care Management; or

2.7.6.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.8 Payment

2.8.1 AAH receives payment from DHCS and disperses funds in a timely manner to CS Providers through collection and submission of data by the CS Provider, and through the contractual agreement made between AAH and the CS Provider.

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

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

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

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

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

2.9 Restrictions and Limitations

2.9.1 Community Supports (CS) are alternative services to covered benefits under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. In lieu of service can only be covered by AAH if:

2.9.1.1 The State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service;

2.9.1.2 Beneficiaries are not required to use the in lieu of service; and

2.9.1.3 The in lieu of service is authorized and identified in the AAH plan contracts.

2.9.2 Housing Deposits will be available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. AAH will make a good faith effort to review information available to them to determine if individual has previously received services.

2.9.3 These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.

2.9.4 Individuals will also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

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

2.10 Discontinuing Services

2.10.1 Discontinuing of CS services will be based on:

2.10.1.1 Meeting the lifetime maximum financial limitation

2.10.1.2 Goals met/completion of housing deposit

2.10.1.3 No longer meets criteria

2.10.1.4 Member/caregiver declines services

2.10.1.5 Death of member

2.10.2 CS provider will submit weekly reports identifying AAH members who have completed the CS service.

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

2.11 Licensing and Allowable Providers

2.11.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.11.2 The entity that is coordinating an individual's Housing Transition Navigation Services, or AAH's case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

2.11.3 AAH will ensure CS Providers have demonstrated or verifiable experience and expertise with providing these unique services.

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

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

DEFINITIONS / ACRONYMS

CS	Community Supports
HCSA	Health Care Services Agency

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CRE-018 Assessment of Community Supports Organizational Providers

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024

REFERENCES

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

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	~~CM-023~~CS-004
Policy Name	Community Supports – Housing Tenancy and Sustaining Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/16/2024~~TBD
Compliance Committee Approval Date	~~3/19/2024~~TBD

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

1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS – Housing Tenancy and Sustaining Services for their CS clients experiencing homelessness and housing instability.

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

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

1.4.1 AAH engages with local providers of primary care, specialty care, care

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

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

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

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

1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.

PROCEDURE

2.1 AAH provides tenancy and sustaining services through their CS network of providers, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

2.1.1 Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

2.1.2 Education and training on the role rights and responsibilities of the tenant and landlord.

2.1.3 Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

2.1.4 Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

2.1.5 Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.

2.1.6 Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

2.1.7 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

2.1.8 Assistance with the annual housing recertification process.

2.1.9 Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

2.1.10 Continuing assistance with lease compliance, including ongoing support with activities related to household management.

2.1.11 Health and safety visits, including unit habitability inspections.

2.1.12 Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

2.1.13 Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

2.2 Housing Tenancy and Sustaining Services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

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

2.4 AAH will coordinate services with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

2.5 Housing Tenancy and Sustaining Services do not include the provision of room and board or payment of rental costs. Please see housing deposits CS.

2.6 Member Identification

2.6.1 Report Based CS

2.6.1.1 Monthly, the Analytics department runs a Population Report, using data from all members using the specific Housing criteria to identify members.

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

2.6.1.2.1 Notification of Eligibility

2.6.1.2.1.1 Member are notified of Housing eligibility via written communication.

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2.6.3 Assignment to CS Providers will be determined using factors, including the member's

location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

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

2.7 Request for Housing Tenancy and Sustaining Services

2.7.1 AAH verifies a member's health plan eligibility

2.7.1.1 Request is reviewed

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

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

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

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

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

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

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

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

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

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

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

2.9.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

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

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

2.10 Payment

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

2.10.2 AAH will adhere to standard claims processing turn-around times for claims, invoices

or encounter data that will be reimbursed on a fee-for-service basis as follows:

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

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

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

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

2.11 Eligibility

2.11.1 Any individual who received Housing Transition/Navigation Services CS in counties that offer Housing Transition/Navigation Services.

2.11.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.11.3 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.11.4 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.11.4.1 In W&I Code section 14127I as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.11.4.2 By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the

number of days in the institution) as:

2.11.4.2.1 A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.11.4.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.11.4.2.1.2 Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.11.4.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

2.11.4.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.11.5 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.11.5.1 (1) An individual or family who:

2.11.5.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.11.5.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

2.11.5.1.2.1 Meets one of the following conditions:

2.11.5.1.2.1.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.11.5.1.2.1.2 Is living in the home of another because of economic hardship;

2.11.5.1.2.1.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.11.5.1.3 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.11.5.1.4 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.11.5.1.5 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.11.5.1.6 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.11.5.2 (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.11.5.3 (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.11.6 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.11.6.1 Have one or more serious chronic conditions;

2.11.6.2 Have a Serious Mental Illness;

2.11.6.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.11.6.4 Have a Serious Emotional Disturbance (children and adolescents);

2.11.6.5 Are receiving Enhanced Care Management; or

2.11.6.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who

have been victims of trafficking, or

2.11.7 Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.12 Restrictions / Limitations

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

2.12.2 Housing Tenancy and Sustaining Services will be available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. AAH will make a good faith effort to review information available to them to determine if individual has previously received services. Service duration can be as long as necessary.

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2.12.4 Many individuals will have also received Housing Transition Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

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

2.13 Discontinuing Services

2.13.1 Discontinuing of CS services will be based on:

2.13.1.1 Goals met/completion of housing support plan

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2.13.1.3 Unable to maintain contact with member

2.13.1.4 No longer meets criteria

2.13.1.5 Member/caregiver declines services

2.13.1.6 Death of member

2.13.2 CS provider will submit weekly reports identifying AAH members who have completed the CS service.

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

2.14 Licensing / Allowable Providers

2.14.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.14.2 If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. AAH will coordinate with county homelessness entities to provide these services.

2.14.3 Clients who meet the eligibility requirements for Housing and Tenancy Support Services will also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers. When clients receive more than one of these services, AAH will ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

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

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

DEFINITIONS / ACRONYMS

CS	Community Supports
HCSA	Health Care Services Agency

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CRE-018 Assessment of Community Supports Organizational Providers

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024

REFERENCES

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

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH

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

POLICY AND PROCEDURE

Policy Number	CS-004
Policy Name	Community Supports – Housing Tenancy and Sustaining Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

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

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

1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS – Housing Tenancy and Sustaining Services for their CS clients experiencing homelessness and housing instability.

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

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

1.4.1 AAH engages with local providers of primary care, specialty care, care

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

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

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

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

1.5 Access points for housing services are spread throughout the entire county; more access points located in areas of greater need.

PROCEDURE

2.1 AAH provides tenancy and sustaining services through their CS network of providers, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

2.1.1 Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

2.1.2 Education and training on the role rights and responsibilities of the tenant and landlord.

2.1.3 Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

2.1.4 Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

2.1.5 Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.

2.1.6 Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

2.1.7 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

2.1.8 Assistance with the annual housing recertification process.

2.1.9 Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

2.1.10 Continuing assistance with lease compliance, including ongoing support with activities related to household management.

2.1.11 Health and safety visits, including unit habitability inspections.

2.1.12 Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

2.1.13 Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

2.2 Housing Tenancy and Sustaining Services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

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

2.4 AAH will coordinate services with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

2.5 Housing Tenancy and Sustaining Services do not include the provision of room and board or payment of rental costs. Please see housing deposits CS.

2.6 Member Identification

2.6.1 Report Based CS

2.6.1.1 Monthly, the Analytics department runs a Population Report, using data from all members using the specific Housing criteria to identify members.

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

2.6.1.2.1 Notification of Eligibility

2.6.1.2.1.1 Member are notified of Housing eligibility via written communication.

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

2.6.2 Referral Based CS

2.6.3 Assignment to CS Providers will be determined using factors, including the member's

location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

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

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

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

2.7 Request for Housing Tenancy and Sustaining Services

2.7.1 AAH verifies a member's health plan eligibility

2.7.1.1 Request is reviewed

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

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

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

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

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

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

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

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

2.8 Continuity of Care

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

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

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

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

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

2.9 Data Sharing

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

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

2.9.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

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

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

2.10 Payment

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

2.10.2 AAH will adhere to standard claims processing turn-around times for claims, invoices

or encounter data that will be reimbursed on a fee-for-service basis as follows:

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

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

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

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

2.11 Eligibility

2.11.1 Any individual who received Housing Transition/Navigation Services CS in counties that offer Housing Transition/Navigation Services.

2.11.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.11.3 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

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

2.14 Licensing / Allowable Providers

2.14.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.14.2 If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. AAH will coordinate with county homelessness entities to provide these services.

2.14.3 Clients who meet the eligibility requirements for Housing and Tenancy Support Services will also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers. When clients receive more than one of these services, AAH will ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

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DEFINITIONS / ACRONYMS

CS	Community Supports
HCSA	Health Care Services Agency

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CRE-018 Assessment of Community Supports Organizational Providers

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024

REFERENCES

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MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

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

POLICY AND PROCEDURE

Policy Number	~~CM-024~~CS-002
Policy Name	Community Supports – Housing Transition Navigation Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/16/2024~~TBD
Compliance Committee Approval Date	~~3/19/2024~~TBD

POLICY STATEMENT

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

1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS Housing Transition and Navigation Services for their CS clients experiencing homelessness and housing instability.

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

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

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

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

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PROCEDURE

2.1 AAH provides Housing Transition Navigation services through their CS network of providers, with a goal of assisting members with housing transition and navigation services. Services include:

2.1.1 Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.

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2.2 Housing Transition Navigation Services provided will be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

2.3 AAH services provided will utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.

2.4 AAH will coordinate services with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, AAH will work closely with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. AAH and its contracted CS Providers will coordinate access to housing resources (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) through county behavioral health when appropriate.

2.5 Services do not include the provision of room and board or payment of rental costs. AAH will coordinate with local entities to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

2.6 Member Identification.

AAH identifies eligible members through the following mechanisms:

2.6.1 Report Based CS

~~2.6.1.0~~2.6.1.1 [illegible] all members using the specific Housing criteria to identify members.

~~2.6.1.1~~2.6.1.2 The Population Report is provided to the Community Supports (CS) department monthly for further processing.

2.7 Notification of Eligibility

2.7.1 Members are notified of Housing eligibility via written communication.

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

2.8 Referral Based CS

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

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

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

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

2.9 Request for Housing Transition Navigation Services

2.9.1 AAH verifies a member's health plan eligibility.

2.9.1.1 Request is reviewed

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

2.9.1.3 Member and provider are notified in accordance with UM Policy, 057, Authorization Service Request.

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

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

implemented.

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

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

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

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

2.10 Continuity of Care

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

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

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

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

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

2.11 Data Sharing

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

2.11.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional

data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.11.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

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

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

2.12 Eligibility

2.12.1 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.12.2 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.12.3 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.12.3.1 In W&I Code section 14127I as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.12.3.2 By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.12.3.2.1 A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.12.3.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.12.3.2.1.2 Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.12.3.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

2.12.3.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.12.4 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.12.4.1 (1) An individual or family who:

2.12.4.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.12.4.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

2.12.4.1.3 Meets one of the following conditions:

2.12.4.1.3.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.12.4.1.3.2 Is living in the home of another because of economic hardship;

2.12.4.1.3.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after

the date of application for assistance;

2.12.4.1.3.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.12.4.1.3.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.12.4.1.3.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.12.4.1.3.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.12.4.1.4 (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.12.4.1.5 (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.12.5 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.12.5.1 Have one or more serious chronic conditions;

2.12.5.2 Have a Serious Mental Illness;

2.12.5.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.12.5.4 Have a Serious Emotional Disturbance (children and adolescents);

2.12.5.5 Are receiving Enhanced Care Management; or

2.12.5.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the

juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

2.12.6 Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.13 Payment

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

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

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

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

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

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

2.14 Restrictions and Limitations

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

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

2) beneficiaries are not required to use the Community Supports and

3) the Community Supports are authorized and identified in the AAH plan contracts.

2.14.2 Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan. Service duration can be as long as necessary. AAH will ensure that individuals are not receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.15 Discontinuing Services

2.15.1 Discontinuing of CS services will be based on:

2.15.1.1 Goals met/obtain permanent housing

2.15.1.2 Termination of coverage

2.15.1.3 Unable to establish or maintain contact with member

2.15.1.4 No longer meets criteria

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2.15.1.6 Death of member

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Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
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2.9.1 AAH verifies a member's health plan eligibility.

2.9.1.1 Request is reviewed

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

2.9.1.3 Member and provider are notified in accordance with UM Policy, 057, Authorization Service Request.

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

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

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

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

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

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

2.10 Continuity of Care

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

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

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

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

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

2.11 Data Sharing

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

2.11.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an

ad hoc report will be created and sent to the provider.

2.11.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

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

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

2.12 Eligibility

2.12.1 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.12.2 Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.12.3 Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

2.12.3.1 In W&I Code section 14127I as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

2.12.3.2 By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

2.12.3.2.1 A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

2.12.3.2.1.1 Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2.12.3.2.1.2 Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

2.12.3.2.2 An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

2.12.3.2.3 A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

2.12.4 Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.12.4.1 (1) An individual or family who:

2.12.4.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.12.4.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

2.12.4.1.3 Meets one of the following conditions:

2.12.4.1.3.1 Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

2.12.4.1.3.2 Is living in the home of another because of economic hardship;

2.12.4.1.3.3 Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after

the date of application for assistance;

2.12.4.1.3.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

2.12.4.1.3.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.12.4.1.3.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.12.4.1.3.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.12.4.1.4 (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.12.4.1.5 (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.12.5 Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.12.5.1 Have one or more serious chronic conditions;

2.12.5.2 Have a Serious Mental Illness;

2.12.5.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder

2.12.5.4 Have a Serious Emotional Disturbance (children and adolescents);

2.12.5.5 Are receiving Enhanced Care Management; or

2.12.5.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the

juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

2.12.6 Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

2.13 Payment

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

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

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

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

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

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

2.14 Restrictions and Limitations

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

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

2) beneficiaries are not required to use the Community Supports and

3) the Community Supports are authorized and identified in the AAH plan contracts.

2.14.2 Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan. Service duration can be as long as necessary. AAH will ensure that individuals are not receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.15 Discontinuing Services

2.15.1 Discontinuing of CS services will be based on:

2.15.1.1 Goals met/obtain permanent housing

2.15.1.2 Termination of coverage

2.15.1.3 Unable to establish or maintain contact with member

2.15.1.4 No longer meets criteria

2.15.1.5 Member/caregiver declines services

2.15.1.6 Death of member

2.15.2 CS provider will submit weekly reports identifying AAH members who have completed the CS service.

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

2.16 Licensing / Allowable Providers

2.16.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.16.2 Clients who meet the eligibility requirements for Housing Transition/Navigation services will also be assessed for Community Supports Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers. When clients receive more than one of these services, AAH will ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

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

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

DEFINITIONS / ACRONYMS

None

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CRE-018 Assessment of Community Supports Organizational Providers

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024

REFERENCES

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

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	~~CM-025~~CS-007
Policy Name	Community Supports – Medically Supportive Food/Meals/Medically Tailored Meals
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/16/2024~~TBD
Compliance Committee Approval Date	~~3/19/2024~~TBD

POLICY STATEMENT

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

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

1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS Medically Supportive Food/Meals/Medically Tailored Meals to their CS clients.

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

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

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through

newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

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

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

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

PROCEDURE

2.1 AAH Medically Supportive Food/Meals/Medically Tailored Meals may include:

2.1.1 Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.

2.1.2 Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.

2.1.3 Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

2.1.4 Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers, and food pharmacies.

2.1.5 Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

2.2 Member Identification

2.2.1 Report Based CS

2.2.1.1 AAH Analytics produces a monthly Population Report, using medical and pharmacy data for all members and includes the specific Medically Supportive Food/Meals/Medically Tailored Meals criteria to identify members.

2.2.1.2 The Population Report is provided to the AAH CS team for further processing.

2.2.1.1 Notification of Eligibility

2.2.1.2.1.1 Members are notified of Medically Supportive Food/Meals/Medically Tailored Meals eligibility via telephonic communication.

2.2.2 Referrals Based CS

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

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

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

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

2.3 Request for Medically Supportive Food/Meals/Medically Tailored Meals Services

2.3.1 AAH verifies a member's health plan eligibility.

2.3.1.1 Request is reviewed

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

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

2.3.2 Urgent request for Medically Supportive Food/Meals/Medically Tailored Meals services will follow the standard AAH timeline in accordance with UM-051, Timeliness of UM Decision Making and Notification.

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

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

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

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

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

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

2.4 Continuity of Care

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

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

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

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

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

2.5 Data Sharing

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

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

2.5.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

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

2.5.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.6 Eligibility

2.6.1 Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

2.6.2 Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

2.6.3 Individuals with extensive care coordination needs.

2.7 Restrictions / Limitations

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

2.7.1.1 Up to two (2) medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.

2.7.1.2 Meals that are eligible for or reimbursed by alternate programs are not eligible.

2.7.1.3 Meals are not covered to respond solely to food insecurities.

2.7.2 Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using AAH funding.

2.8 Payment

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

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

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

follows:

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

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

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

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

2.9 Discontinuing Services

2.9.1 Discontinuing of CS services will be based on:

2.9.1.1 Goals met/completion of meal program with no extension needed

2.9.1.2 Termination of coverage

2.9.1.3 Unable to establish or maintain contact with member

2.9.1.4 No longer meets criteria

2.9.1.5 Member/caregiver declines services

2.9.1.6 Death of member

2.9.2 CS provider will notify AAH CS team if member terminates program early.

2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System at authorization expiration.

2.10 Licensing / Allowable Providers

2.10.1 CS Medically Tailored Meals/Medically Supportive Foods Providers must have experience and expertise with providing these unique services.

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

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

DEFINITIONS / ACRONYMS

CS	Community Supports
HCSA	Health Care Services Agency

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024

REFERENCES

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

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

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

POLICY AND PROCEDURE

Policy Number	CS-007
Policy Name	Community Supports – Medically Supportive Food/Meals/Medically Tailored Meals
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

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

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

1.3 Through oversight and auditing AAH ensures that CS Providers are incorporating CS Medically Supportive Food/Meals/Medically Tailored Meals to their CS clients.

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

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

1.4.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through

newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

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

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

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

PROCEDURE

2.1 AAH Medically Supportive Food/Meals/Medically Tailored Meals may include:

2.1.1 Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.

2.1.2 Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.

2.1.3 Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

2.1.4 Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers, and food pharmacies.

2.1.5 Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

2.2 Member Identification

2.2.1 Report Based CS

2.2.1.1 AAH Analytics produces a monthly Population Report, using medical and pharmacy data for all members and includes the specific Medically Supportive Food/Meals/Medically Tailored Meals criteria to identify members.

2.2.1.2 The Population Report is provided to the AAH CS team for further processing.

2.2.1.1 Notification of Eligibility

2.2.1.2.1.1 Members are notified of Medically Supportive Food/Meals/Medically Tailored Meals eligibility via telephonic communication.

2.2.2 Referrals Based CS

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

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

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

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

2.3 Request for Medically Supportive Food/Meals/Medically Tailored Meals Services

2.3.1 AAH verifies a member's health plan eligibility.

2.3.1.1 Request is reviewed

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

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

2.3.2 Urgent request for Medically Supportive Food/Meals/Medically Tailored Meals services will follow the standard AAH timeline in accordance with UM-051, Timeliness of UM Decision Making and Notification.

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

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

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

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

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

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

2.4 Continuity of Care

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

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

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

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

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

2.5 Data Sharing

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

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

2.5.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

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

2.5.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.6 Eligibility

2.6.1 Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

2.6.2 Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

2.6.3 Individuals with extensive care coordination needs.

2.7 Restrictions / Limitations

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

2.7.1.1 Up to two (2) medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.

2.7.1.2 Meals that are eligible for or reimbursed by alternate programs are not eligible.

2.7.1.3 Meals are not covered to respond solely to food insecurities.

2.7.2 Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using AAH funding.

2.8 Payment

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

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

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

follows:

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

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

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

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

2.9 Discontinuing Services

2.9.1 Discontinuing of CS services will be based on:

2.9.1.1 Goals met/completion of meal program with no extension needed

2.9.1.2 Termination of coverage

2.9.1.3 Unable to establish or maintain contact with member

2.9.1.4 No longer meets criteria

2.9.1.5 Member/caregiver declines services

2.9.1.6 Death of member

2.9.2 CS provider will notify AAH CS team if member terminates program early.

2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System at authorization expiration.

2.10 Licensing / Allowable Providers

2.10.1 CS Medically Tailored Meals/Medically Supportive Foods Providers must have experience and expertise with providing these unique services.

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

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

DEFINITIONS / ACRONYMS

CS	Community Supports
HCSA	Health Care Services Agency

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024

REFERENCES

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

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	~~CM-026~~CS-006
Policy Name	Community Supports – Recuperative Care (Medical Respite)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/16/2024~~TBD
Compliance Committee Approval Date	~~3/19/2024~~TBD

POLICY STATEMENT

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

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

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

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

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

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

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

PROCEDURE

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

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

2.1.2 Coordination of transportation to post-discharge appointments

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

2.1.4 Support in accessing benefits and housing

2.1.5 Gaining stability with case management relationships and programs

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

2.3 AAH services provided will utilize best practices for clients who are experiencing

homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.4 Member Identification

2.4.1 Referrals Based CS

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

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

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

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

2.4.5 Notification of Eligibility

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

2.5 Request for Recuperative Care (Medical Respite) Services

2.5.1 AAH verifies a member's health plan eligibility.

2.5.1.1 Request is reviewed

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

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

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

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

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

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

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

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

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

2.6 Continuity of Care

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

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

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

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

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

2.7 Data Sharing

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

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

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

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

2.7.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.8 Eligibility

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

2.8.2 Individuals who live alone with no formal supports; or

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

2.9 Payment

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

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

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

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

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

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

2.10 Restrictions and Limitations

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

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

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

2.11 Discontinuing Services

2.11.1 Discontinuing of CS services will be based on:

2.11.1.1 Goals met/improved health status

2.11.1.2 Termination of coverage

2.11.1.3 No longer meets criteria

2.11.1.4 Member/caregiver declines services

2.11.1.5 Death of member

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

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

2.12 Licensing / Allowable Providers

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

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

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

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

CM-026 Community Supports – Recuperative Care (Medical Respite)

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024

REFERENCES

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

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

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

POLICY AND PROCEDURE

Policy Number	CS-006
Policy Name	Community Supports – Recuperative Care (Medical Respite)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

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

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

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

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

1.4 Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

- AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.
- The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.
- The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.
- Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 At a minimum, AAH's service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

2.1.1 Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs

2.1.2 Coordination of transportation to post-discharge appointments

2.1.3 Connection to any other on-going services an individual may require including mental health and substance use disorder services

2.1.4 Support in accessing benefits and housing

2.1.5 Gaining stability with case management relationships and programs

2.2 AAH services provided to an individual while in recuperative care will not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other housing Community Supports will be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, Community Supports will be managed in coordination with enhanced care management providers.

2.3 AAH services provided will utilize best practices for clients who are experiencing

homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.4 Member Identification

2.4.1 Referrals Based CS

2.4.2 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.4.3 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

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2.4.5 Notification of Eligibility

2.4.5.1 AAH will notify members of Recuperative Care (Medical Respite) eligibility via telephonic communication.

2.5 Request for Recuperative Care (Medical Respite) Services

2.5.1 AAH verifies a member's health plan eligibility.

2.5.1.1 Request is reviewed

2.5.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.5.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

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2.5.5 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.5.6 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.5.7 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.5.8 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.6 Continuity of Care

2.6.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.6.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.6.2.1 AAH offers the CS service which the member received through their prior MCP.

2.6.2.2 The CS service does not have any lifetime limits (frequency or financial) that have already been reached.

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2.7 Data Sharing

2.7.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.7.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.7.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.7.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.7.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.8 Eligibility

2.8.1 Individuals who are at risk of hospitalization or are post-hospitalization, and

2.8.2 Individuals who live alone with no formal supports; or

2.8.3 Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.

2.9 Payment

2.9.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.9.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.9.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.9.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.9.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.9.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.10 Restrictions and Limitations

2.10.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

2.10.2 Recuperative care/medical respite is an allowable Community Supports service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

2.10.3 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.11 Discontinuing Services

2.11.1 Discontinuing of CS services will be based on:

2.11.1.1 Goals met/improved health status

2.11.1.2 Termination of coverage

2.11.1.3 No longer meets criteria

2.11.1.4 Member/caregiver declines services

2.11.1.5 Death of member

2.11.2 CS provider will notify AAH CS team of AAH members who have discharged from Medical Respite within 1 week of discharge.

2.11.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.12 Licensing / Allowable Providers

2.12.1 AAH CS Providers must have experience and expertise with providing these unique services.

2.12.2 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.12.3 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance
Cultural and Linguistic Services

RELATED POLICIES AND PROCEDURES

CM-026 Community Supports – Recuperative Care (Medical Respite)

CLS-009 CLS Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

06/22/2022, 01/11/2023, 3/19/2024

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
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Service you can trust.

POLICY AND PROCEDURE

Policy Number	~~CM-027~~CS-001
Policy Name	Community Supports – Oversight, Monitoring & Controls
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~2/16/2024~~TBD
Compliance Committee Approval Date	~~3/19/2024~~TBD

POLICY STATEMENT

1.1. In order to provide Community Supports (CS) services to eligible Alameda Alliance for Health (AAH) Medi-Cal members, AAH contracts with a network of CS Providers.

1.2. AAH ensures that CS Providers comply with program requirements as outlined in CalAIM Program.

1.2.1. Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.3. AAH takes a proactive approach to ensuring authorization for CS in a medically appropriate, equitable, and non-discriminatory manner. Each interested CS provider is required to go through a pre-certification process. The pre-certification includes requesting proof of culturally-competent and linguistically-appropriate services. AAH seeks to contract with a diverse set of providers to ensure non-discrimination, specifically in the area of diverse language capacity. AAH also employs a culturally diverse staff. Once a provider has been contracted, training is provided which has cultural sensitivity practices built in. Also, non-discriminatory practices are inherent to the annual Population Needs Assessment and Population Health Management Strategy,

both of which are drivers in the selection process for bringing on new CS services.

1.4. AAH monitors and evaluates the effectiveness and cost-effectiveness of the CS services.

PROCEDURE

2.1 Auditing and Oversight of CS Provider Activities

2.1.1 AAH will conduct auditing and oversight of CS Provider activities through the following:

2.1.1.1 Monthly monitoring of CS and reports;

2.1.1.2 Quarterly monitoring of AAH internal and regulatory reports; and

2.1.1.3 Annual CS Provider onsite visits and case file review appropriate to the category of CS. These visits may be done remotely, as necessary.

2.2 CS Data and Reports

2.2.1 AAH will collect and monitor CS services utilizing operational and clinical data, including data submitted from CS Providers as well as internal data.

2.2.2 Data submitted from CS Providers will be monitored for completeness and data accuracy to meet all reporting requirements set forth by AAH and DHCS.

2.2.3 AAH Analytics team will develop CS reports that will include utilization by approved, denied, and received services as well as by other categories such as CS service and provider. Additional reporting may include financial, Grievance and Appeals, and other utilization and quality metric reports.

2.2.4 In addition, AAH will produce and monitor all regulatory reporting as required by DHCS.

2.2.5 Reports will be produced on a monthly and/or quarterly basis and distributed to the appropriate teams for monitoring and review.

2.2.6 Analysis of effectiveness and cost-effectiveness of CS Services

2.2.6.1 Pre-approved CS services have been deemed cost-effective alternatives to State Plan Covered services or settings by DHCS, taking into consideration the results of the Whole Person Care (WPC) and Health Homes Pilot (HHP).

2.2.6.2 AAH will perform annual analysis of CS members to evaluate whether a CS is a cost-effective alternative to a State Plan Covered service or setting. Financial and utilization analysis of members receiving CS will be included. Industry standard metrics will be used to analyze utilization patterns and trends across care settings as well as total costs for the CS population.

2.2.6.3 Diversity and equity utilization metrics will be analyzed and compared against AAH's overall population. The outcomes of these analyses will

provide information as to whether any modifications should be made to the CS service offering. Appropriate lag times will be incorporated as necessary. Should evaluation findings identify instances where service authorizations have had an inequitable effect, a special task force, including the provider, will be convened to identify the root cause. Interventions would include re-training, enhanced outreach and network development, as needed, to focus on quality initiatives.

2.2.7 AAH's CS, Analytics and Quality teams utilize information obtained and incorporate CS data into Plan Quality Activities. AAH staff will utilize information obtained to define and drive improvement through interventions and education with targeted providers who have unique or outlying issues or identified trends.

2.3 CS Provider Onsite Visits and Case File Reviews

2.3.1 AAH CS Staff perform site visits, when possible, in order to evaluate CS operational and care management activities.

2.3.1.1 Year 1: AAH staff will perform onsite (when possible) visits at least once during the first year and more frequently if issues are identified through the quarterly reports of CS Provider activities.

2.3.1.2 Year 2 and beyond: AAH staff will perform onsite (when possible) visits annually in order to assess CS activities. Onsite visits will assess both operational and care management activities of the CS Providers.

2.3.1.3 Operational areas to be reviewed include:

- Staffing, including Case Ratios as applicable
- Reporting and tracking systems
- Program development
- Staff training

2.3.2 Case File Review: A random sample of cases , using 8/30 methodology will be reviewed for evidence of required CS Care Management services including:

2.3.2.1 Outreach and engagement

2.3.2.2 Communication between CS Care Team members and Primary Care provider

2.3.2.3 Process metrics specific to the category of CS being provided to assess compliance with regulatory, contractual and programmatic requirements.

2.3.2.4 Incorporation of Trauma Informed Care practices

2.3.3 AAH will work collaboratively with CS Providers in order to identify and address solutions and resolve any areas of deficiency.

2.3.4 If a corrective approach to deficiency cannot be agreed upon, then a formal CAP may be required.

2.3.5 If a CAP is requested and the CS Provider does not meet or is unable to meet the CAP requirements, request for escalation to the Chief Medical Officer or Designee will be requested for further corrective action and remediation to ensure that the CS Provider is meeting CS program delivery requirements.

DEFINITIONS / ACRONYMS

CS	Community Supports
AAH	Alameda Alliance for Health
DHCS	Department of Health Care Services
CAP	Corrective Action Plan
HEDIS	Healthcare Effectiveness Data and Information Set

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Credentialing

RELATED POLICIES AND PROCEDURES

CRE-018 Credentialing and Recredentialing of Community Supports Providers

REVISION HISTORY

01/11/2023, 3/19/2024

REFERENCES

California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021

MONITORING

Monthly schedule will be established and shared with CS providers at the beginning of each year for scheduled CS Provider oversight & monitoring.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CS-001
Policy Name	Community Supports – Oversight, Monitoring & Controls
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Social Determinants of Health
Line(s) of Business	MCAL
Effective Date	01/01/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

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AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Credentialing

RELATED POLICIES AND PROCEDURES

CRE-018 Credentialing and Recredentialing of Community Supports Providers

REVISION HISTORY

01/11/2023, 3/19/2024

REFERENCES

California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021

MONITORING

Monthly schedule will be established and shared with CS providers at the beginning of each year for scheduled CS Provider oversight & monitoring.

POLICY AND PROCEDURE

Policy Number	CM-029
Policy Name	Developmental Disabilities
Department Name	Case and Disease Management
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	All
Effective Date	11/4/2005
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	~~5/19/2023~~TBD
Compliance Committee Approval Date	~~TB~~TBD

POLICY STATEMENT

1) Alameda Alliance for Health (the Alliance):

a) Maintains a Memorandum of Understanding (MOU) with Regional Center of the East Bay (RCEB) for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of services for eligible members suspected of having developmental disabilities.

b) Collaborates with the Regional Center of the East Bay (RCEB) to establish mutually agreeable policies and procedures for problem resolution that include the following:

i) Appoints a liaison, as needed, to review and resolve complaints concerning conflicts between the Alliance and RCEB regarding program eligibility, diagnostic testing, plan of treatment, and associated benefits for the member's care;

ii) Refers unresolved problems to the Alliance's DHCS contract manager and to the State Department of Developmental Services or California Department of Education (CDE) office.

iii) Determination of medically necessary diagnostic and preventative services and treatment plans for members.

iv) Case management and care coordination to ensure the provision of all medically necessary covered services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

c) Implements and maintains systems to identify members with developmental disabilities that may meet requirements for participation in a Home and Community Based Services (HCBS) Waiver program and ensures that these members are referred to the appropriate HCBS Waiver program administered by the State Department of Developmental Services;

i) AAH refers members with developmental disabilities to Regional Center of the East Bay (RCEB) for evaluation and access to non-medical services provided by RCEB, including, but not limited to, respite, out-of-home placement, and supportive living.

d) Continues to provide comprehensive case management services and cover all medically necessary services for the members who meet criteria and are placed in a HCBS Waiver program while remaining enrolled with the Alliance;

e) Continues to provide comprehensive case management services and cover all medically necessary services for the members who do not meet criteria for placement in a HCBS Waiver program while remaining enrolled with the Alliance;

2) Contracted PCPs and specialists (practitioners) are responsible for the identification and referral of members with developmental disabilities/behavioral health disorders outside their scope of practice as follows:

a) Medi-Cal members referred to the Regional Center of the East Bay (RCEB). RCEB collaborates with the plan regarding Behavioral Health referrals and informs families how to reach out to the plan for referral to the designated Behavioral Health organization.

b) Other line of business members referred to the designated Behavioral Health organization.

c) Preventive care will be provided according to the most recent American Academy of Pediatrics (AAP) Guidelines for Children and the Guidelines of the United States Preventive Services Task Force (USPTF) for adults.

3) Members identified with or suspected of having developmental disabilities receive all medically necessary and appropriate developmental screening, primary preventive services, and diagnostic and treatment services.

4) The Alliance provides genetic counseling and other covered prenatal genetic testing services when medically indicated for Members at risk of parenting a child with a developmental disability.

5) Data files identifying plan members receiving RCEB services will be forwarded to the appropriate assigned PCPs and delegated medical groups.

PROCEDURE

Primary Care and Specialty Referrals

A. PCPs are required to provide all necessary primary care for individuals with developmental disabilities including:

1. Well Child Exams;
2. Immunizations;

3. Developmental status screening;
4. Illness or Injury Care;
5. Diagnostic testing (laboratory, x-rays) as needed;
6. Health Education as needed; and
7. Other primary care services as needed.

B. PCPs are required to arrange for and/or request from the Alliance all medically necessary specialty practitioner, diagnostic, or therapeutic services including:
   1. Referral to specialist or sub-specialist practitioners (e.g., neurologists, physiatrists);
   2. Referrals for occupational or physical therapy
   3. Orders for medically necessary durable medical equipment (DME) or home health services; and
   4. Referrals/authorizations for specialized diagnostic testing (e.g., CT or MRI).

C. Alliance Utilization Management (UM) staff arranges for all necessary specialty care for Members, including out-of-network referrals as needed due to the condition of the Member.

D. The Alliance covers prenatal genetic diagnostic testing for those Members whose PCPs or OB practitioners identify a need.

E. PCPs and Alliance UM are responsible for referral to RCEB for Members in need of non-medical, home, and community-based services such as:
   1. Family support;
   2. Day habilitation;
   3. Respite care; and/or
   4. Residential care or assisted living.

F. PCPs and Alliance UM are responsible for referral to Behavior Health organization for members in need of non-medical, home and community-based services such as:
   1. Training in skills for daily living;
   2. Acquisition of skills and behavior and/or;
      a. Exception: if a family requests American Disabilities Act (ADA) services, the family will be referred back to RCEB.

G. PCPs and Alliance UM are responsible for referrals of children (over 36 months of age) and adults suspected of having developmental disabilities to RCEB when requested by the Member, or his/her family if a minor.
   1. The Member's disability must originate before the 18th birthday, be expected to continue indefinitely, and constitute a substantial disability.
   2. A list of definitions and eligibility criteria can be found in the California Code of Regulations (CCR) Title 22 Sections 54000, 54001, 54002, and 54010.
   3. RCEB reviews referrals to determine RCEB eligibility and considers the need for developmental programs or family support services that are not available from other resources.
   4. For referral procedures for children aged 0 to 36 months see Policy UM-021 Early Start.

H. Referrals to RCEB from the PCP or Alliance UM, should be directed to the RCEB's intake coordinator and include the following information:

1. The reason for referral;
2. The complete medical history and physical examination, including appropriate developmental screens;
3. The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated; and
4. The referral should be directed to:

a. For children 3 years old and under:

- Early Start Program

  Phone: 510-618-6195

  Fax: 510-678-4156

  Email: EarlyStartReferrals@rceb.org

b. For children over 3 years old:

Phone: 510-618-6122

Fax: 510-678-4122

Email: intakeoverthree@rceb.org

* RCEB Medical Consultants are available for consultations on appropriate medical tests necessary for obtaining a specific diagnosis.

I. Intake staff reviews the referral to the RCEB within 15 working days of receipt. Evaluations must be performed within 120 days following review of referral, or sooner if a delay in assessment would expose the Member to unnecessary risk to health and safety. RCEB notifies the Member and the Alliance (if the Alliance provides RCEB with a release of information form signed by the Member) within 120 days after the referral is made regarding the Member's eligibility and recommendations for services.

J. Alliance UM is responsible for approving medically necessary referrals.

K. Alliance CM is responsible for the following activities:

1. Providing care coordination services for Members regardless of whether or not they receive services from RCEB.
2. Assisting the PCP as needed with the referral to RCEB, including arranging for transfer of medical information, and contact with RCEB.
3. Coordinating necessary follow-up as needed between the PCP, specialty practitioners, and RCEB to assure an organized care plan and delivery for the Member.
4. Participating with RCEB staff, as indicated, in the development of the Individual Program Plan required for all persons with developmental disabilities to include identification of medical care services that need to be provided to the member.

Commented [LK1]: Individual Program Plan

5. Maintaining liaison with the Regional Center of the East Bay to:

a. Assist members with developmental disabilities to understand and access services.
b. Act as a central point of contact for questions, access and care concerns, and

problem resolution as required by Welfare and Institutions Code 14182 (c) (10).

L. See UM- 0017 Home and Community Based Services (Waiver) Programs for policy and procedures pertaining to HCBS.

M. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 *Delegation Oversight* for monitoring of delegation oversight.

Commented [HL2]: Old naming convention

DEFINITIONS

Home and Community Based Waiver Programs (HCBS) – Creative alternatives, allowed under federal law, eligible for Medi-Cal members. These services are to be implemented in the home or community for certain Medi-Cal beneficiaries to avoid hospitalization or nursing facility placement. Services provided under a waiver program are not typically part of the managed Medi-Cal plan benefit. These programs include, but are not limited to, the nursing facility/acute hospital (NF/AH) waiver.

Regional Center of the East Bay (RCEB) – The Regional Center of the East Bay (RCEB) is a private, non-profit corporation under contract with the California Department of Developmental Services. RCEB works in partnership with many individuals and other agencies to plan and coordinate services and supports for people with developmental disabilities. A community-based Board of Directors - which includes individuals with developmental disabilities, family members and community leaders - provides guidance and leadership.

AFFECTED DEPARTMENTS/PARTIES

Utilization Mgmt.
Member Services
Provider Services
Case Management

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

UM-008 Coordination of Care – California Children's Services (CCS)
UM-012 Coordination of Care-Behavioral Health
UM-017 Home and Community Based (Waiver) Services
UM-021 Early Start

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/20/2009, 6/9/2009, 4/1/2011, 6/1/2011, 8/30/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 3/22/2022, 6/28/2022, 6/20/2023, 9/19/2023

REFERENCES

1. MMCD APL 07-012 Identification of Regional Center Consumers.
2. MMCD Policy Letter 97-03 Services for Members with Developmental Disabilities
3. DHCS Contract Exhibit A, Attachment 11, Provision 10

MONITORING

The Compliance and Case and Disease Management Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

POLICY AND PROCEDURE

Policy Number	CM-029
Policy Name	Developmental Disabilities
Department Name	Case and Disease Management
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	All
Effective Date	11/4/2005
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

1) Alameda Alliance for Health (the Alliance):

a) Maintains a Memorandum of Understanding (MOU) with Regional Center of the East Bay (RCEB) for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of services for eligible members suspected of having developmental disabilities.

b) Collaborates with the Regional Center of the East Bay (RCEB) to establish mutually agreeable policies and procedures for problem resolution that include the following:

i) Appoints a liaison, as needed, to review and resolve complaints concerning conflicts between the Alliance and RCEB regarding program eligibility, diagnostic testing, plan of treatment, and associated benefits for the member's care;

ii) Refers unresolved problems to the Alliance's DHCS contract manager and to the State Department of Developmental Services or California Department of Education (CDE) office.

iii) Determination of medically necessary diagnostic and preventative services and treatment plans for members.

iv) Case management and care coordination to ensure the provision of all medically necessary covered services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

c) Implements and maintains systems to identify members with developmental disabilities that may meet requirements for participation in a Home and Community Based Services (HCBS) Waiver program and ensures that these members are referred to the appropriate HCBS Waiver program administered by the State Department of Developmental Services;

i) AAH refers members with developmental disabilities to Regional Center of the East Bay (RCEB) for evaluation and access to non-medical services provided by RCEB, including, but not limited to, respite, out-of-home placement, and supportive living.

d) Continues to provide comprehensive case management services and cover all medically necessary services for the members who meet criteria and are placed in a HCBS Waiver program while remaining enrolled with the Alliance;

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c) Preventive care will be provided according to the most recent American Academy of Pediatrics (AAP) Guidelines for Children and the Guidelines of the United States Preventive Services Task Force (USPTF) for adults.

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3. Developmental status screening;
4. Illness or Injury Care;
5. Diagnostic testing (laboratory, x-rays) as needed;
6. Health Education as needed; and
7. Other primary care services as needed.

B. PCPs are required to arrange for and/or request from the Alliance all medically necessary specialty practitioner, diagnostic, or therapeutic services including:
   1. Referral to specialist or sub-specialist practitioners (e.g., neurologists, physiatrists);
   2. Referrals for occupational or physical therapy
   3. Orders for medically necessary durable medical equipment (DME) or home health services; and
   4. Referrals/authorizations for specialized diagnostic testing (e.g., CT or MRI).

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   3. Respite care; and/or
   4. Residential care or assisted living.

F. PCPs and Alliance UM are responsible for referral to Behavior Health organization for members in need of non-medical, home and community-based services such as:
   1. Training in skills for daily living;
   2. Acquisition of skills and behavior and/or;
      a. Exception: if a family requests American Disabilities Act (ADA) services, the family will be referred back to RCEB.

G. PCPs and Alliance UM are responsible for referrals of children (over 36 months of age) and adults suspected of having developmental disabilities to RCEB when requested by the Member, or his/her family if a minor.
   1. The Member's disability must originate before the 18th birthday, be expected to continue indefinitely, and constitute a substantial disability.
   2. A list of definitions and eligibility criteria can be found in the California Code of Regulations (CCR) Title 22 Sections 54000, 54001, 54002, and 54010.
   3. RCEB reviews referrals to determine RCEB eligibility and considers the need for developmental programs or family support services that are not available from other resources.
   4. For referral procedures for children aged 0 to 36 months see Policy UM-021 Early Start.

H. Referrals to RCEB from the PCP or Alliance UM, should be directed to the RCEB's intake coordinator and include the following information:

1. The reason for referral;
2. The complete medical history and physical examination, including appropriate developmental screens;
3. The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated; and
4. The referral should be directed to:

a. For children 3 years old and under:

- Early Start Program

Phone: 510-618-6195

Fax: 510-678-4156

Email: EarlyStartReferrals@rceb.org

b. For children over 3 years old:

Phone: 510-618-6122

Fax: 510-678-4122

Email: intakeoverthree@rceb.org

* RCEB Medical Consultants are available for consultations on appropriate medical tests necessary for obtaining a specific diagnosis.

I. Intake staff reviews the referral to the RCEB within 15 working days of receipt. Evaluations must be performed within 120 days following review of referral, or sooner if a delay in assessment would expose the Member to unnecessary risk to health and safety. RCEB notifies the Member and the Alliance (if the Alliance provides RCEB with a release of information form signed by the Member) within 120 days after the referral is made regarding the Member's eligibility and recommendations for services.

J. Alliance UM is responsible for approving medically necessary referrals.

K. Alliance CM is responsible for the following activities:

1. Providing care coordination services for Members regardless of whether or not they receive services from RCEB.
2. Assisting the PCP as needed with the referral to RCEB, including arranging for transfer of medical information, and contact with RCEB.
3. Coordinating necessary follow-up as needed between the PCP, specialty practitioners, and RCEB to assure an organized care plan and delivery for the Member.
4. Participating with RCEB staff, as indicated, in the development of the Individual Program Plan required for all persons with developmental disabilities to include identification of medical care services that need to be provided to the member.

Commented [LK1]: Individual Program Plan

5. Maintaining liaison with the Regional Center of the East Bay to:

a. Assist members with developmental disabilities to understand and access services.
b. Act as a central point of contact for questions, access and care concerns, and

problem resolution as required by Welfare and Institutions Code 14182 (c) (10).

L. See UM- 0017 Home and Community Based Services (Waiver) Programs for policy and procedures pertaining to HCBS.

M. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 *Delegation Oversight* for monitoring of delegation oversight.

Commented [HL2]: Old naming convention

DEFINITIONS

Home and Community Based Waiver Programs (HCBS) – Creative alternatives, allowed under federal law, eligible for Medi-Cal members. These services are to be implemented in the home or community for certain Medi-Cal beneficiaries to avoid hospitalization or nursing facility placement. Services provided under a waiver program are not typically part of the managed Medi-Cal plan benefit. These programs include, but are not limited to, the nursing facility/acute hospital (NF/AH) waiver.

Regional Center of the East Bay (RCEB) – The Regional Center of the East Bay (RCEB) is a private, non-profit corporation under contract with the California Department of Developmental Services. RCEB works in partnership with many individuals and other agencies to plan and coordinate services and supports for people with developmental disabilities. A community-based Board of Directors - which includes individuals with developmental disabilities, family members and community leaders - provides guidance and leadership.

AFFECTED DEPARTMENTS/PARTIES

Utilization Mgmt.
Member Services
Provider Services
Case Management

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

UM-008 Coordination of Care – California Children's Services (CCS)
UM-012 Coordination of Care-Behavioral Health
UM-017 Home and Community Based (Waiver) Services
UM-021 Early Start

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/20/2009, 6/9/2009, 4/1/2011, 6/1/2011, 8/30/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 3/22/2022, 6/28/2022, 6/20/2023, 9/19/2023

REFERENCES

1. MMCD APL 07-012 Identification of Regional Center Consumers.
2. MMCD Policy Letter 97-03 Services for Members with Developmental Disabilities
3. DHCS Contract Exhibit A, Attachment 11, Provision 10

MONITORING

The Compliance and Case and Disease Management Departments will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.

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POLICY AND PROCEDURE

Policy Number	CM-033
Policy Name	Home and Community Based Services (Waiver Programs) DDS
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	Medi-Cal
Effective Date	10/21/2005
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	~~5/19/2023~~TBD
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

A. Alliance delegates contracted PCPs and specialists (practitioners) with the responsibility to identify and refer Medi-Cal Managed Care Plan (MCP) members, that may meet participation requirements, to any of the following Home and Community Based Services (HCBS) Waiver Programs administered by the State Department of Developmental Services (DDS):

1. Developmentally Disabled (DD) Waiver.
2. HCBA Waiver (formerly the Nursing Facility/Acute Hospital (NF/AH, NF/AB, NF/Sub-acute Waiver)
3. Multi-purpose Senior Service Program (MSSP) Waiver
4. HIV/AIDS Waiver
    a. MCP members diagnosed with HIV/AIDS after enrollment may participate in the Waiver program, if program placement is available, and may remain enrolled in the MCP.
    b. Persons already enrolled in the HIV/AIDS Waiver program may voluntarily enroll in an MCP.
5. California Community Transitions (CCT)
6. Assisted Living Waiver (ALW)

7. 1915(i) SPA:DD-RC (State Plan Amendment-Developmentally Disabled-Regional Center)

B. Alliance members who are potentially eligible for HCBS Waiver Programs will be referred to the appropriate program through the DHCS In-Home Operations.

C. Members accepted into the HCBS Waiver Program remain enrolled in the Alliance. The assigned PCP and the Alliance remain responsible for all other medically necessary treatment unrelated to the services provided by the HCBS Waiver Program.

D. The Alliance will continue to provide medically necessary and comprehensive case management services appropriate for the member's medical condition for anyone who does and does not meet waiver program criteria or for whom placement is denied or unavailable.

1. The CM staff will assess and coordinate with appropriate agency to ensure there is no duplication of services. (This includes members receiving TCM.)

E. The Alliance will initiate the disenrollment process, when appropriate, after a member is accepted into a waiver program.

F. Delegated Medical Groups (DMGs) delegated to perform case management (CM) activities are responsible for assisting practitioners with identification and referral of Members to the HCBS Waiver Program

PROCEDURE

A. Referring practitioners identify Members with potential DDS -administered HCBS Waiver Program needs. Criteria for eligibility include:

1. Residency in Alameda County.
2. Identification of a developmental disability originating before the individual's 18th birthday which is continuing or can be expected to continue indefinitely.
3. Documentation of a substantial developmental disability including mental retardation, cerebral palsy, epilepsy, autism, and other disabilities found to be closely related to mental retardation or conditions that require treatment similar to mentally retarded individuals. Learning disabilities or disabilities that are solely psychological or psychiatric in nature are not covered under the HCBS Program Waiver.

B. Practitioners, with the assistance of the Alliance, are responsible for the submission of applicable medical records and a request for services. Depending on the waiver program, enrollment is managed in different locations. By referring to: https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx for further guidance.

1. Members who may qualify for one of the Waiver Programs will be identified by their PCP, with Utilization Management (UM) and Case and Disease Management (CMDM) Departments support, based on their diagnosis and need for a specific level of care.
2. The CMDM Department will inform Waiver Program candidates and their PCPs of the application process to ensure that the member is fully aware.
    a. Requests for waiver services may come from Medi-Cal providers, associated agencies, beneficiaries, families, friends, or advocates.
    b. Based upon the information on the Waiver application, the evaluator will determine if the individual meets the criteria for the HCBS waiver and discuss the waiver and waiver services that are available.
    c. Each HCBS waiver can only serve a limited number of individuals. Once that limit is reached, the names of individuals requesting waiver services will be placed on a waiting list based upon the date received their completed HCBS Waiver application.
    d. The Alliance CMDM staff may contact the Waiver Program to determine the status of a waiver request and determine if the member has been accepted into the Waiver Program.
3. If the member's waiver program application is not approved, the Alliance will continue to provide all medically necessary services appropriate for the member's medical condition.
4. In the event of denial for a Waiver Program for an Alliance member because there is no space available, the Alliance CMDM nurse will maintain contact with the appropriate agency in the event space does become available and the member might be reconsidered.

C. Once the Member has been approved for placement, the Alliance assists with coordinating available services through the HCBS Waiver Program through the following methods:

    1. Maintenance of continuity of care through coordination with RCEB Case Managers.

    2. Coordination with the PCP to ensure medically necessary health care services for conditions not eligible in the HCBS Waiver Program.

    3. Maintenance of a continuous and unimpeded flow of medical information between practitioners. The PCP obtains medical records of health care services provided for conditions eligible for HCBS Waiver Program services.

D. Providers will be informed about Waiver Programs through the Provider Manual.
E. Members will be informed of the AAH policy regarding waiver programs through the Evidence of Coverage (EOC).
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.

DEFINITIONS

Home and Community Based Waiver Programs (HCBS) – Creative alternatives, allowed under federal law, eligible for Medi-Cal members. These services are to be implemented in the home or community for certain Medi-Cal beneficiaries to avoid hospitalization or nursing

facility placement. The services available under these HCBS Waivers include case management, community transition services, private duty nursing, family training, home health aides, life-sustaining utility reimbursement, habilitation services, and respite care. Services provided under a waiver program are not typically part of the managed Medi-Cal plan benefit. These programs include, but are not limited to, the Home and Community-Based Alternatives (HCBA) Waiver – Formerly Nursing Facility/Acute Hospital (NF/AH) waiver.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CM-029 Developmental Disabilities
UM-029 Sensitive Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/20/2009, 6/1/2011, 8/30/2012, 5/13/2013, 4/21/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 9/19/2023

REFERENCES

1. DHCS Contract Exhibit A, Attachment 11, Provision 21
2. MMCD Policy Letter 97-03 Services for Members with Developmental Disabilities
3. Social Security Act §1915(c)

MONITORING

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POLICY AND PROCEDURE

Policy Number	CM-033
Policy Name	Home and Community Based Services (Waiver Programs) DDS
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Medical Director
Lines of Business	Medi-Cal
Effective Date	10/21/2005
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

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3. If the member's waiver program application is not approved, the Alliance will continue to provide all medically necessary services appropriate for the member's medical condition.
4. In the event of denial for a Waiver Program for an Alliance member because there is no space available, the Alliance CMDM nurse will maintain contact with the appropriate agency in the event space does become available and the member might be reconsidered.

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AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CM-029 Developmental Disabilities
UM-029 Sensitive Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 1/20/2009, 6/1/2011, 8/30/2012, 5/13/2013, 4/21/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 9/19/2023

REFERENCES

1. DHCS Contract Exhibit A, Attachment 11, Provision 21
2. MMCD Policy Letter 97-03 Services for Members with Developmental Disabilities
3. Social Security Act §1915(c)

MONITORING

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POLICY AND PROCEDURE

Policy Number	~~CM-035~~CS-008
Policy Name	Community Supports – Respite Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	~~07/01/2023~~TBD
Approval/Revision Date	~~Xx/xx/2023~~TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Respite Services for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Respite Services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through

newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.5.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 Respite Services can include any of the following:

2.1.1 Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.

2.1.2 Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

2.1.3 Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite Services are provided to the Member in his or her own home or another location being used as the home.

Facility Respite Services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

2.2 Member Identification

2.2.1 Referrals Based CS

2.2.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.2.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH

for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.2.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.2.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1–888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.3 Request for Respite Services

2.3.1 Once AAH verifies a member's health plan eligibility:

2.3.1.1 Request is reviewed.

2.3.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.3.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.3.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.3.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.3.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.3.4..1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.3.4..1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.3.4..2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.4 Continuity of Care

2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy

through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.4.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.4.2..1 AAH offers the CS service which the member received through their prior MCP.

2.4.3 AAH will automatically authorize the CS service when the above conditions are met.

2.5 Data Sharing

2.5.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.5.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.5.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.5.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.5.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.6 Eligibility

2.6.1 Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

2.6.2 Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.

2.7 Payment

2.7.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.7.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.7.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.7.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.7.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.7.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.8 Restrictions and Limitations

2.8.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

2.8.2 In the home setting, Respite Services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of care. The service limit is up to 336 hours per calendar year and is inclusive of all in-home and in-facility services.

2.8.3 Exceptions to the 336 hour per calendar year limit can be made, with AAH authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves the Member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

2.8.4 This service is only to avoid placements for which AAH would be responsible.

2.8.5 Respite services cannot be provided virtually, or via telehealth.

2.8.6 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.9 Discontinuing Services

2.9.1 Discontinuing of CS services will be based on:

2.9.1.1 Goals met/improved health status

2.9.1.2 Termination of coverage

2.9.1.3 No longer meets criteria

2.9.1.4 Member/caregiver declines services

2.9.1.5 Death of member

2.9.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.

2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.10 Licensing / Allowable Providers

2.10.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Respite Care.

2.10.2 AAH CS Providers must have experience and expertise with providing these unique services.

2.10.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.10.3.1CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

2.10.4 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.10.5 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CS-008
Policy Name	Community Supports – Respite Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	TBD
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Respite Services for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Respite Services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through

newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.5.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 Respite Services can include any of the following:

2.1.1 Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.

2.1.2 Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

2.1.3 Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite Services are provided to the Member in his or her own home or another location being used as the home.

Facility Respite Services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

2.2 Member Identification

2.2.1 Referrals Based CS

2.2.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.2.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH

for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.2.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.2.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1–888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.3 Request for Respite Services

2.3.1 Once AAH verifies a member's health plan eligibility:

2.3.1.1 Request is reviewed.

2.3.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.3.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.3.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.3.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.3.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.3.4..1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.3.4..1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.3.4..2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.4 Continuity of Care

2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy

through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.4.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.4.2..1 AAH offers the CS service which the member received through their prior MCP.

2.4.3 AAH will automatically authorize the CS service when the above conditions are met.

2.5 Data Sharing

2.5.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.5.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.5.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.5.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.5.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.6 Eligibility

2.6.1 Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

2.6.2 Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.

2.7 Payment

2.7.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.7.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.7.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.7.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.7.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.7.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.8 Restrictions and Limitations

2.8.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

2.8.2 In the home setting, Respite Services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of care. The service limit is up to 336 hours per calendar year and is inclusive of all in-home and in-facility services.

2.8.3 Exceptions to the 336 hour per calendar year limit can be made, with AAH authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves the Member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

2.8.4 This service is only to avoid placements for which AAH would be responsible.

2.8.5 Respite services cannot be provided virtually, or via telehealth.

2.8.6 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.9 Discontinuing Services

2.9.1 Discontinuing of CS services will be based on:

2.9.1.1 Goals met/improved health status

2.9.1.2 Termination of coverage

2.9.1.3 No longer meets criteria

2.9.1.4 Member/caregiver declines services

2.9.1.5 Death of member

2.9.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.

2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.10 Licensing / Allowable Providers

2.10.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Respite Care.

2.10.2 AAH CS Providers must have experience and expertise with providing these unique services.

2.10.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.10.3.1CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

2.10.4 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.10.5 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	~~CM-036~~CS-009
Policy Name	Community Supports – Personal Care and Homemaker Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	~~07/01/2023~~TBD
Approval/Revision Date	~~Xx/xx/2023~~TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Personal Care and Homemaker Services for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Personal Care Services and Homemaker Services are provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management.

1.5 This CS includes services provided through the In-Home Support Services (IHSS) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

1.6 Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes.

1.7 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.7.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.7.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.7.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.7.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 The Personal Care and Homemaker Services Community Support can be utilized:

2.1.1 Above and beyond any approved county IHSS hours, when additional hours are required and if IHSS benefits are exhausted; and

2.1.2 As authorized during any IHSS waiting period (Member must be already referred to IHSS); this approval time period includes services prior to and up through the IHSS application date.

2.1.3 For Members not eligible to receive IHSS, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through IHSS should always be utilized first. These Personal Care and Homemaker services should only be utilized if appropriate and if additional hours/supports are not authorized by IHSS.

2.2 Member Identification

2.2.1 Referrals Based CS

2.2.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.2.1.2 A Provider, health plan staff member, CS staff member, other non-

provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.2.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.2.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1–888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.3 Request for Personal Care and Homemaker Services

2.3.1 Once AAH verifies a member's health plan eligibility:

2.3.1.1 Request is reviewed.

2.3.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.3.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.3.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.3.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.3.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.3.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.3.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.3.4.1.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.4 Continuity of Care

2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.4.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.4.2.1 AAH offers the CS service which the member received through their prior MCP.

2.4.3 AAH will automatically authorize the CS service when the above conditions are met.

2.5 Data Sharing

2.5.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.5.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.5.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.5.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.5.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.6 Eligibility

2.6.1 Individuals at risk for hospitalization, or institutionalization in a nursing facility; or

2.6.2 Individuals with functional deficits and no other adequate support system; or

2.6.3 Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

2.7 Payment

2.7.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.7.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.7.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.7.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.7.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.7.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.8 Restrictions and Limitations

2.8.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

2.8.2 This service cannot be utilized in lieu of referring to the In-Home Supportive Services (IHSS) program. Member must be referred to the IHSS program when they meet referral criteria.

2.8.3 If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to IHSS for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period

2.8.4 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.9 Discontinuing Services

2.9.1 Discontinuing of CS services will be based on:

2.9.1.1 Goals met/improved health status

2.9.1.2 Termination of coverage

2.9.1.3 No longer meets criteria

2.9.1.4 Member/caregiver declines services

2.9.1.5 Death of member

2.9.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.

2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.10 Licensing / Allowable Providers

2.10.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Personal Care and Homemaker Services.

2.10.2 AAH CS Providers must have experience and expertise with providing these unique services.

2.10.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.10.3.1 CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

2.10.4 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.10.5 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CS-009
Policy Name	Community Supports – Personal Care and Homemaker Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	TBD
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Personal Care and Homemaker Services for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Personal Care Services and Homemaker Services are provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management.

1.5 This CS includes services provided through the In-Home Support Services (IHSS) program, including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

1.6 Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes.

1.7 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.7.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.7.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.7.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.7.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 The Personal Care and Homemaker Services Community Support can be utilized:

2.1.1 Above and beyond any approved county IHSS hours, when additional hours are required and if IHSS benefits are exhausted; and

2.1.2 As authorized during any IHSS waiting period (Member must be already referred to IHSS); this approval time period includes services prior to and up through the IHSS application date.

2.1.3 For Members not eligible to receive IHSS, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through IHSS should always be utilized first. These Personal Care and Homemaker services should only be utilized if appropriate and if additional hours/supports are not authorized by IHSS.

2.2 Member Identification

2.2.1 Referrals Based CS

2.2.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.2.1.2 A Provider, health plan staff member, CS staff member, other non-

provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.2.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.2.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1–888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.3 Request for Personal Care and Homemaker Services

2.3.1 Once AAH verifies a member's health plan eligibility:

2.3.1.1 Request is reviewed.

2.3.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.3.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.3.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.3.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.3.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.3.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.3.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.3.4.1.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.4 Continuity of Care

2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.4.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.4.2.1 AAH offers the CS service which the member received through their prior MCP.

2.4.3 AAH will automatically authorize the CS service when the above conditions are met.

2.5 Data Sharing

2.5.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.5.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.5.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.5.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.5.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.6 Eligibility

2.6.1 Individuals at risk for hospitalization, or institutionalization in a nursing facility; or

2.6.2 Individuals with functional deficits and no other adequate support system; or

2.6.3 Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

2.7 Payment

2.7.1 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.7.2 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.7.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.7.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.7.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.7.3 PMPM payments will be provided for applicable CS services (e.g., housing).

2.8 Restrictions and Limitations

2.8.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

2.8.2 This service cannot be utilized in lieu of referring to the In-Home Supportive Services (IHSS) program. Member must be referred to the IHSS program when they meet referral criteria.

2.8.3 If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to IHSS for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period

2.8.4 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.9 Discontinuing Services

2.9.1 Discontinuing of CS services will be based on:

2.9.1.1 Goals met/improved health status

2.9.1.2 Termination of coverage

2.9.1.3 No longer meets criteria

2.9.1.4 Member/caregiver declines services

2.9.1.5 Death of member

2.9.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.

2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.10 Licensing / Allowable Providers

2.10.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Personal Care and Homemaker Services.

2.10.2 AAH CS Providers must have experience and expertise with providing these unique services.

2.10.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.10.3.1 CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

2.10.4 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.10.5 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	~~CM-037~~CS-010
Policy Name	Community Supports – Environmental Accessibility Adaptations (Home Modifications)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	~~07/01/2023~~TBD
Approval/Revision Date	~~Xx/xx/2023~~TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Personal Care and Homemaker Services for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.5.2 The Provider Services Department ensures compliance of providers and subcontractors

with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 Examples of environmental accessibility adaptions include:

2.1.1 Ramps and grab-bars to assist Members in accessing the home;

2.1.2 Doorway widening for Members who require a wheelchair;

2.1.3 Stair lifts;

2.1.4 Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).

2.1.5 Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and

2.1.6 Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

2.2 When authorizing environmental accessibility adaptations as a CS, AAH must receive and document the follow:

2.2.1 The participants current primary care physician or other health professional's order specifying:

2.2.1.1 the requested equipment or service

2.2.1.2 documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the member, including any supporting documentation describing the efficacy of the equipment where appropriate

2.2.1.3 Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the member describing how and why the equipment or service meets the needs of the member will still be necessary.

2.2.2 A physical or occupational therapy evaluation and report to evaluate the medical

necessity of the requested equipment or service (unless the Alliance determines it is appropriate to approve without an evaluation).

2.2.2.1 This evaluation and report should come from an entity with no connection to the provider of the requested equipment or services

2.2.2.2 The evaluation and report should contain the following (at a minimum):

2.2.2.2.1 An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;

2.2.2.2.2 An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member and reduces the risk of institutionalization. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and

2.2.2.2.3 A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.

2.2.3 If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

2.2.4 That a home visit has been conducted to determine the suitability of any requested equipment or service.

2.2.5 The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

2.3 Member Identification

2.3.1 Referrals Based CS

2.3.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.3.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.3.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.3.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1– 888-

433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.4 Request for Environmental Accessibility Adaptations (Home Modifications)

2.4.1 Once AAH verifies a member's health plan eligibility:

2.4.1.1 Request is reviewed.

2.4.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.4.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.4.2 CS services are voluntary and member can agree or choose not to receive the services without having any impact on their other services or benefits.

2.4.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.4.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.4.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.4.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.4.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.5 Continuity of Care

2.5.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.5.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.5.2.1 AAH offers the CS service which the member received through their prior MCP.

2.5.3 AAH will automatically authorize the CS service when the above conditions are met.

2.6 Data Sharing

2.6.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.6.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.6.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.6.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.6.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.7 Eligibility

2.7.1 Individuals at risk for institutionalization in a nursing facility.

2.8 Payment

2.8.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.

2.8.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.8.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.8.3.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.8.3.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.8.3.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.8.4 PMPM payments will be provided for applicable CS services (e.g., housing).

2.9 Restrictions and Limitations

2.9.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and

identified in the AAH managed care plan contracts.

2.9.2 AAH will not use the Environmental Accessibility Adaptations (Home Modifications) CS if another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.

2.9.3 EAAs must be conducted in accordance with applicable State and local building codes.

2.9.4 EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

2.9.5 EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

2.9.6 Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

2.9.7 Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), AAH will provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.

2.9.8 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.10 Discontinuing Services

2.10.1 Discontinuing of CS services will be based on:

2.10.1.1 Goals met/improved health status

2.10.1.2 Termination of coverage

2.10.1.3 No longer meets criteria

2.10.1.4 Member/caregiver declines services

2.10.1.5 Death of member

2.10.2 CS Providers will submit monthly reports identifying AAH members who have

completed the CS service.

2.10.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.11 Licensing / Allowable Providers

2.11.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for EEAs.

2.11.2 AAH CS Providers must have experience and expertise with providing these unique services.

2.11.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.11.3.1 CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

2.11.4 All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License except for a PERS installation, which may be performed in accordance with the system's installation requirements.

2.11.5 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.11.6 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Provider
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CS-010
Policy Name	Community Supports – Environmental Accessibility Adaptations (Home Modifications)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	TBD
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Personal Care and Homemaker Services for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.5.2 The Provider Services Department ensures compliance of providers and subcontractors

with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 Examples of environmental accessibility adaptions include:

2.1.1 Ramps and grab-bars to assist Members in accessing the home;

2.1.2 Doorway widening for Members who require a wheelchair;

2.1.3 Stair lifts;

2.1.4 Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).

2.1.5 Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and

2.1.6 Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

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2.2.1.2 documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the member, including any supporting documentation describing the efficacy of the equipment where appropriate

2.2.1.3 Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the member describing how and why the equipment or service meets the needs of the member will still be necessary.

2.2.2 A physical or occupational therapy evaluation and report to evaluate the medical

necessity of the requested equipment or service (unless the Alliance determines it is appropriate to approve without an evaluation).

2.2.2.1 This evaluation and report should come from an entity with no connection to the provider of the requested equipment or services

2.2.2.2 The evaluation and report should contain the following (at a minimum):

2.2.2.2.1 An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;

2.2.2.2.2 An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member and reduces the risk of institutionalization. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and

2.2.2.2.3 A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.

2.2.3 If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

2.2.4 That a home visit has been conducted to determine the suitability of any requested equipment or service.

2.2.5 The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

2.3 Member Identification

2.3.1 Referrals Based CS

2.3.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.3.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.3.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.3.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1– 888-

433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.4 Request for Environmental Accessibility Adaptations (Home Modifications)

2.4.1 Once AAH verifies a member's health plan eligibility:

2.4.1.1 Request is reviewed.

2.4.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.4.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

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2.4.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.4.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.4.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.5 Continuity of Care

2.5.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.5.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.5.2.1 AAH offers the CS service which the member received through their prior MCP.

2.5.3 AAH will automatically authorize the CS service when the above conditions are met.

2.6 Data Sharing

2.6.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.6.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.6.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.6.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.6.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.7 Eligibility

2.7.1 Individuals at risk for institutionalization in a nursing facility.

2.8 Payment

2.8.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.

2.8.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.8.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.8.3.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.8.3.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.8.3.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.8.4 PMPM payments will be provided for applicable CS services (e.g., housing).

2.9 Restrictions and Limitations

2.9.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and

identified in the AAH managed care plan contracts.

2.9.2 AAH will not use the Environmental Accessibility Adaptations (Home Modifications) CS if another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.

2.9.3 EAAs must be conducted in accordance with applicable State and local building codes.

2.9.4 EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

2.9.5 EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

2.9.6 Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

2.9.7 Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), AAH will provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.

2.9.8 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.10 Discontinuing Services

2.10.1 Discontinuing of CS services will be based on:

2.10.1.1 Goals met/improved health status

2.10.1.2 Termination of coverage

2.10.1.3 No longer meets criteria

2.10.1.4 Member/caregiver declines services

2.10.1.5 Death of member

2.10.2 CS Providers will submit monthly reports identifying AAH members who have

completed the CS service.

2.10.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.11 Licensing / Allowable Providers

2.11.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for EEAs.

2.11.2 AAH CS Providers must have experience and expertise with providing these unique services.

2.11.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.11.3.1 CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

2.11.4 All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License except for a PERS installation, which may be performed in accordance with the system's installation requirements.

2.11.5 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.11.6 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Provider
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	~~CM-038~~CS-011
Policy Name	Community Supports – Nursing Facility Transition/Diversion to Assisted Living Facilities
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	~~01/01/2024~~TBD
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Nursing Facility Transition/Diversion to Assisted Living Facilities for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Nursing Facility Transition/Diversion to Assisted Living Facilities services assist individuals to live in the community and/or avoid institutionalization when possible.

1.4.1 The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-

discriminatory and equitable services.

1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.5.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 The assisted living provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

2.2 This Community Support is for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) or Adult Residential Facilities (ARF)and includes wrap-around services such as assistance w/ ADLs and IADLs as needed, companion services, medical oversight, and therapeutic social recreational programming provided in a home-like environment. It includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

2.2.1 Assessing the Member's housing needs and presenting options.

2.2.2 Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.

2.2.3 Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

2.2.4 Communicating with facility administration and coordinating the move.

2.2.5 Establishing procedures and contacts to retain facility housing.

2.2.6 Coordinating with the Alliance to ensure that the needs of Members who need enhanced services to be safely and stably housing in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.

2.3 Member Identification

2.3.1 Referrals Based CS

2.3.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.3.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.3.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.3.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1–888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.4 Request for Nursing Facility Diversion/Transition to Assisted Living Facilities

2.4.1 Once AAH verifies a member's health plan eligibility:

2.4.1.1 Request is reviewed.

2.4.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.4.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.4.2 CS services are voluntary, and members can agree or choose not to receive the services without having any impact on their other services or benefits.

2.4.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.4.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.4.4.1 If the member is enrolled in ECM, the referral would be sent back to the

ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.4.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.4.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.5 Continuity of Care

2.5.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.5.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.5.2.1 AAH offers the CS service which the member received through their prior MCP.

2.5.3 AAH will automatically authorize the CS service when the above conditions are met.

2.6 Data Sharing

2.6.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.6.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.6.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.6.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.6.5 AAH Collects, analyzes, and reports financial measures, health status, and other

measures and outcome data to be reported as requested or per DHCS' guidelines.

2.7 Eligibility

2.7.1 For Nursing Facility Transition:

1.1 The Member has resided 60+ days in a nursing facility;

2.1 The Member is willing to live in an assisted living setting as an alternative to a Nursing Facility; and

3.1 The Member is able to reside safely in an assisted living facility with appropriate and cost-effective supports.

2.7.2 For Nursing Facility Diversion:

1.1 The Member is interested in remaining in the community;

2.1 The Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

3.1 The Member must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

2.8 Payment

2.8.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.

2.8.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.8.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.8.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.8.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.8.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.8.4 PMPM payments will be provided for applicable CS services (e.g., housing).

2.9 Restrictions and Limitations

2.9.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if:

1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

2.9.2 Individuals are directly responsible for paying their own living expenses.

2.9.3 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.10 Discontinuing Services

2.10.1 Discontinuing of CS services will be based on:

2.10.1.1 Goals met/improved health status

2.10.1.2 Termination of coverage

2.10.1.3 No longer meets criteria

2.10.1.4 Member/caregiver declines services

2.10.1.5 Death of member

2.10.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.

2.10.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.11 Licensing / Allowable Providers

2.11.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Nursing Facility Transition/Diversion to Assisted Living Facilities.

2.11.2 AAH CS Providers must have experience and expertise with providing these unique services. An example of the types of providers AAH may choose to contract with includes, but is not limited to:

2.11.2.1 Case management agencies

2.11.2.2 Home Health agencies

2.11.2.3 ARF/RCFE Operators

2.11.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.11.4 CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

2.11.5 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.11.6 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CS-011
Policy Name	Community Supports – Nursing Facility Transition/Diversion to Assisted Living Facilities
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	TBD
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Nursing Facility Transition/Diversion to Assisted Living Facilities for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Nursing Facility Transition/Diversion to Assisted Living Facilities services assist individuals to live in the community and/or avoid institutionalization when possible.

1.4.1 The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-

discriminatory and equitable services.

1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.5.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 The assisted living provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

2.2 This Community Support is for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) or Adult Residential Facilities (ARF)and includes wrap-around services such as assistance w/ ADLs and IADLs as needed, companion services, medical oversight, and therapeutic social recreational programming provided in a home-like environment. It includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

2.2.1 Assessing the Member's housing needs and presenting options.

2.2.2 Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.

2.2.3 Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

2.2.4 Communicating with facility administration and coordinating the move.

2.2.5 Establishing procedures and contacts to retain facility housing.

2.2.6 Coordinating with the Alliance to ensure that the needs of Members who need enhanced services to be safely and stably housing in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.

2.3 Member Identification

2.3.1 Referrals Based CS

2.3.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.3.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.3.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

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2.4 Request for Nursing Facility Diversion/Transition to Assisted Living Facilities

2.4.1 Once AAH verifies a member's health plan eligibility:

2.4.1.1 Request is reviewed.

2.4.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.4.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.4.2 CS services are voluntary, and members can agree or choose not to receive the services without having any impact on their other services or benefits.

2.4.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.4.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.4.4.1 If the member is enrolled in ECM, the referral would be sent back to the

ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.4.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.4.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.5 Continuity of Care

2.5.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.5.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

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2.6.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.6.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.6.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.6.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.6.5 AAH Collects, analyzes, and reports financial measures, health status, and other

measures and outcome data to be reported as requested or per DHCS' guidelines.

2.7 Eligibility

2.7.1 For Nursing Facility Transition:

1.1 The Member has resided 60+ days in a nursing facility;

2.1 The Member is willing to live in an assisted living setting as an alternative to a Nursing Facility; and

3.1 The Member is able to reside safely in an assisted living facility with appropriate and cost-effective supports.

2.7.2 For Nursing Facility Diversion:

1.1 The Member is interested in remaining in the community;

2.1 The Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

3.1 The Member must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

2.8 Payment

2.8.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.

2.8.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.8.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.8.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.8.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.8.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.8.4 PMPM payments will be provided for applicable CS services (e.g., housing).

2.9 Restrictions and Limitations

2.9.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if:

1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

2.9.2 Individuals are directly responsible for paying their own living expenses.

2.9.3 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.10 Discontinuing Services

2.10.1 Discontinuing of CS services will be based on:

2.10.1.1 Goals met/improved health status

2.10.1.2 Termination of coverage

2.10.1.3 No longer meets criteria

2.10.1.4 Member/caregiver declines services

2.10.1.5 Death of member

2.10.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.

2.10.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.11 Licensing / Allowable Providers

2.11.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Nursing Facility Transition/Diversion to Assisted Living Facilities.

2.11.2 AAH CS Providers must have experience and expertise with providing these unique services. An example of the types of providers AAH may choose to contract with includes, but is not limited to:

2.11.2.1 Case management agencies

2.11.2.2 Home Health agencies

2.11.2.3 ARF/RCFE Operators

2.11.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.11.4 CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

2.11.5 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.11.6 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

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POLICY AND PROCEDURE

Policy Number	CS-012
Policy Name	Community Supports – Transition Services/Nursing Facility Transition to a Home
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	TBD
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Transition Services/Nursing Facility Transition to a Home for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.

1.5 Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

1.6 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.6.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.6.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.6.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.6.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

2.1.1 Assessing the Member's housing needs and presenting options.

2.1.2 Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

2.1.3 Communicating with landlord (if applicable) and coordinating the move.

2.1.4 Establishing procedures and contacts to retain housing.

2.1.5 Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

2.1.6 Identifying the need for and coordinating the funding for environmental modifications to install necessary accommodations for accessibility.

2.1.7 Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or services access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations.

2.2 Member Identification

2.2.1 Referrals Based CS

2.2.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.2.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.2.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.2.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1–888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.3 Request for Community Transition Services/Nursing Facility Transition to a Home

2.3.1 Once AAH verifies a member's health plan eligibility:

2.3.1.1 Request is reviewed.

2.3.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.3.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.3.2 CS services are voluntary, and members can agree or choose not to receive the services without having any impact on their other services or benefits.

2.3.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.3.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.3.4.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.3.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's

standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.3.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.4 Continuity of Care

2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.4.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.4.2.1 AAH offers the CS service which the member received through their prior MCP.

2.4.3 AAH will automatically authorize the CS service when the above conditions are met.

2.5 Data Sharing

2.5.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.5.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.5.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.5.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.5.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.6 Eligibility

2.6.1 The Member is currently receiving medically necessary nursing facility Level of

Care (LOC) services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition to home and continue to receive medically necessary nursing facility LOC services; and

2.6.2 The Member has lived 60+ days in a nursing home and/or Medical Respite setting; and

2.6.3 The Member is interested in moving back to the community; and

2.6.4 The Member is able to reside safely in the community with appropriate and cost-effective supports and services.

2.7 Payment

2.7.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.

2.7.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.7.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.7.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.7.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.7.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.7.4 PMPM payments will be provided for applicable CS services (e.g., housing).

2.8 Restrictions and Limitations

2.8.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

2.8.2 Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

2.8.3 Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or

her control.

2.8.4 Community Transition Services must be necessary to ensure the health, welfare and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re-institutionalization.

2.8.5 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.9 Discontinuing Services

2.9.1 Discontinuing of CS services will be based on:

2.9.1.1 Goals met/improved health status

2.9.1.2 Termination of coverage

2.9.1.3 No longer meets criteria

2.9.1.4 Member/caregiver declines services

2.9.1.5 Death of member

2.9.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.

2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.10 Licensing / Allowable Providers

2.10.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Transition Services/Nursing Facility Transition to a Home .

2.10.2 AAH CS Providers must have experience and expertise with providing these unique services. An example of the types of providers AAH may choose to contract with includes, but is not limited to:

2.10.2.1 Case management agencies
2.10.2.2 Home Health agencies
2.10.2.3 County mental health providers
2.10.2.4 1915c HCBA/ALW providers

2.10.2.5CCT/Money Follows the Person providers

2.10.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.10.4 CS Providers must be approved by AAH to ensure adequate experience and

appropriate quality of care standards are maintained.

2.10.5 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.10.6 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	~~CM-038~~CS-011
Policy Name	Community Supports – Nursing Facility Transition/Diversion to Assisted Living Facilities
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	~~01/01/2024~~TBD
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Nursing Facility Transition/Diversion to Assisted Living Facilities for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Nursing Facility Transition/Diversion to Assisted Living Facilities services assist individuals to live in the community and/or avoid institutionalization when possible.

1.4.1 The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-

discriminatory and equitable services.

1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters, professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.5.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 The assisted living provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

2.2 This Community Support is for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) or Adult Residential Facilities (ARF)and includes wrap-around services such as assistance w/ ADLs and IADLs as needed, companion services, medical oversight, and therapeutic social recreational programming provided in a home-like environment. It includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

2.2.1 Assessing the Member's housing needs and presenting options.

2.2.2 Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.

2.2.3 Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

2.2.4 Communicating with facility administration and coordinating the move.

2.2.5 Establishing procedures and contacts to retain facility housing.

2.2.6 Coordinating with the Alliance to ensure that the needs of Members who need enhanced services to be safely and stably housing in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.

2.3 Member Identification

2.3.1 Referrals Based CS

2.3.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.3.1.2 A Provider, health plan staff member, CS staff member, other non-provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.3.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.3.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1–888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.4 Request for Nursing Facility Diversion/Transition to Assisted Living Facilities

2.4.1 Once AAH verifies a member's health plan eligibility:

2.4.1.1 Request is reviewed.

2.4.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.4.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.4.2 CS services are voluntary, and members can agree or choose not to receive the services without having any impact on their other services or benefits.

2.4.3 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.4.4 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.4.4.1 If the member is enrolled in ECM, the referral would be sent back to the

ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.4.4.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.4.4.2 If the member is not enrolled in ECM, a referral would be made to the AAH Care Management Department for identification of alternative services.

2.5 Continuity of Care

2.5.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.5.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.5.2.1 AAH offers the CS service which the member received through their prior MCP.

2.5.3 AAH will automatically authorize the CS service when the above conditions are met.

2.6 Data Sharing

2.6.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.6.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.6.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.6.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.6.5 AAH Collects, analyzes, and reports financial measures, health status, and other

measures and outcome data to be reported as requested or per DHCS' guidelines.

2.7 Eligibility

2.7.1 For Nursing Facility Transition:

1.1 The Member has resided 60+ days in a nursing facility;

2.1 The Member is willing to live in an assisted living setting as an alternative to a Nursing Facility; and

3.1 The Member is able to reside safely in an assisted living facility with appropriate and cost-effective supports.

2.7.2 For Nursing Facility Diversion:

1.1 The Member is interested in remaining in the community;

2.1 The Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

3.1 The Member must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

2.8 Payment

2.8.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.

2.8.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.8.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.8.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.8.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.8.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.8.4 PMPM payments will be provided for applicable CS services (e.g., housing).

2.9 Restrictions and Limitations

2.9.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if:

1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

2.9.2 Individuals are directly responsible for paying their own living expenses.

2.9.3 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.10 Discontinuing Services

2.10.1 Discontinuing of CS services will be based on:

2.10.1.1 Goals met/improved health status

2.10.1.2 Termination of coverage

2.10.1.3 No longer meets criteria

2.10.1.4 Member/caregiver declines services

2.10.1.5 Death of member

2.10.2 CS Providers will submit monthly reports identifying AAH members who have completed the CS service.

2.10.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.11 Licensing / Allowable Providers

2.11.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Nursing Facility Transition/Diversion to Assisted Living Facilities.

2.11.2 AAH CS Providers must have experience and expertise with providing these unique services. An example of the types of providers AAH may choose to contract with includes, but is not limited to:

2.11.2.1 Case management agencies

2.11.2.2 Home Health agencies

2.11.2.3 ARF/RCFE Operators

2.11.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.11.4 CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

2.11.5 AAH monitors capacity and indicators, such as grievances associated with access to services and wait times, to ensure adequate capacity. Should the current providers be unable to provide services to all eligible members, AAH will seek out and contract with additional providers to ensure members have appropriate access. Should there be network capacity issues, members will be offered AAH telephonic Case Management services until a space opens with an existing provider or until a community provider is available.

2.11.6 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance

RELATED POLICIES AND PROCEDURES

CLS-009 Cultural and Linguistic Services (CLS) Program – Contracted Providers
CRE-018 Assessment of Community Supports Organizational Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-057 Authorization Service Request

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Community Supports Referral Process Flow

REVISION HISTORY

REFERENCES

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

CM-027 Community Supports – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	~~CM-040~~CS-013
Policy Name	Community Supports – Sobering Centers
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	~~01/01/2024~~TBD
Approval/Revision Date	TBD

POLICY STATEMENT

1.1 Alameda Alliance for Health (AAH) provides linkages and support for the elected Community Supports (CS) options beginning January 1, 2022.

1.2 AAH works with community resources to ensure access to and delivery of CS services.

1.3 Through oversight and auditing, AAH ensures that CS Providers are incorporating CS Sobering Centers for their CS clients.

1.3.1 Delegated CS Providers and/or their subcontractors must follow AAH authorization requirements, including adjudication standards and referral documentation.

1.4 Sobering Centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering Centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

1.5 As indicated in P&P CLS-009, *Cultural and Linguistic Services (CLS) Program – Contracted Providers*, AAH collaborates with providers to provide non-discriminatory and equitable services.

1.5.1 AAH engages with local providers of primary care, specialty care, care management, and Community Supports (CS) services through newsletters,

professional organizations, and public health and non-profit community workgroups to support recruitment of providers who can meet the cultural, language, age and disability needs of our members.

1.5.2 The Provider Services Department ensures compliance of providers and subcontractors with the requirements for access to interpreter services for all limited English proficient (LEP) members.

1.5.3 The Provider Services and Quality Departments collect information on the bilingual capacity of the provider network.

1.5.4 Provider bilingual capacity information is made available to providers and members in the Provider Directory, both paper and online, and is used to appropriately match patients with providers speaking the same language.

PROCEDURE

2.1 Sobering Centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

2.1.1 When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.

2.1.2 The service also includes screening and linkage to ongoing support services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.

2.1.3 This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering Centers must be prepared to identify Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.

2.1.4 The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

2.2 Member Identification

2.2.1 Referrals Based CS

2.2.1.1 Assignment to CS Providers will be determined using factors including the member's location preferences for services, Member's Primary Care Provider (PCP) and Member's location.

2.2.1.2 A Provider, health plan staff member, CS staff member, other non-

provider community entity, Member, or a Member's family member, caregiver or authorized representative(s) may refer a Member to AAH for CS services. AAH will evaluate the request for CS eligibility and if eligible will then connect the Member to a CS Provider for the provision of services.

2.2.1.3 Members who requested one or more CS offered by AAH but were not authorized to receive the CS may submit a Grievance and/or Appeal to AAH.

2.2.2 Members may call AAH Member Services at 1-877-932-2738 or 1-800-735-2929(TTY) during normal business hours or the AAH Nurse Advice Line at 1–888-433-1876 or 1-800-735-2929(TTY) after hours to inquire about CS.

2.3 Request for Sobering Centers

2.3.1 Once AAH verifies a member's health plan eligibility:

2.3.1.1 Request is reviewed.

2.3.1.2 Approval/Denial determination is made per AAH's standard UM process following policy and procedures outlined in UM-057 Authorization Service Request.

2.3.1.3 The member and provider are notified in accordance with AAH's standard UM process following policy and procedures outlined in UM-057, Authorization Service Request.

2.3.2 Urgent request for Sobering Centers services will follow the standard AAH timeline in accordance with UM-051, Timeliness of UM Decision Making and Notification.

2.3.3 CS services are voluntary, and members can agree or choose not to receive the services without having any impact on their other services or benefits.

2.3.4 AAH will use its current UM/CM platform to open and manage referrals. Closed loop referral tracking will be manual until an automated solution is implemented.

2.3.5 If the member does not meet eligibility criteria for the CS service and the servicing provider cannot supply alternative resources:

2.3.5.1 If the member is enrolled in ECM, the referral would be sent back to the ECM Provider. If needed, AAH will assist the ECM Provider to identify alternative resources.

2.3.5.1.1 In terms of coordinating CS referrals with the ECM Provider for members enrolled in ECM, ECM Providers will use AAH's standard referral form and follow the usual referral process (refer to attached Community Supports Referral Process Flow).

2.3.5.2 If the member is not enrolled in ECM, a referral would be made to the

AAH Care Management Department for identification of alternative services.

2.4 Continuity of Care

2.4.1 All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the Plan's Evidence of Coverage and Disclosure Forms, and upon request, the Alliance also sends a copy of the policy to the Member.

2.4.2 Upon request by the Member, Member's family or Authorized Representative, or if AAH becomes aware through other means such as engagement with the Member's prior Medi-Cal Managed Care Plan (MCP) or using the 90-day historical data (when available), newly enrolled Members who were receiving CS through their previous MCP will continue to receive CS services through AAH under the following conditions:

2.4.2.1 AAH offers the CS service which the member received through their prior MCP.

2.4.3 AAH will automatically authorize the CS service when the above conditions are met.

2.5 Data Sharing

2.5.1 AAH establishes and maintains a data-sharing agreement with CS Providers which is compliant with all federal and state laws and regulations. Contracted CS Providers are expected to obtain and document member agreement and data sharing authorization. Data may include Member assignment files, encounters, claims data, physical, behavioral, administrative, and Social Determinants of Health (SDOH) data.

2.5.2 AAH CS Clinical Staff and Analytics Staff support the CS Providers with additional data on member's health histories as needed. If additional information is requested, an ad hoc report will be created and sent to the provider.

2.5.3 AAH and CS Provider accesses available data exchange platform(s) when possible.

2.5.4 AAH tracks and reports CS required quality measures as outlined in the Department of Health Care Services' (DHCS) guidelines.

2.5.5 AAH Collects, analyzes, and reports financial measures, health status, and other measures and outcome data to be reported as requested or per DHCS' guidelines.

2.6 Eligibility

2.6.1 Individuals ages 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering

Center.

2.7 Payment

2.7.1 AAH will ensure payment to Community Support Providers is timely, as required by the DHCS Managed Care Contract Template and CA Health and Safety Code Section 1371.

2.7.2 AAH will disperse funds in a timely manner to CS Providers upon receipt of clean claims/invoices or through collection and submission of encounter data from the CS Provider, based on the contractual agreement made between AAH and the CS Provider.

2.7.3 AAH will adhere to standard claims processing turn-around times for claims, invoices or encounter data that will be reimbursed on a fee-for-service basis as follows:

2.7.2.1 AAH will pay or deny 90% of clean claims within 30 calendar days of receipt

2.7.2.2 AAH will pay or deny 95% of clean claims within 45 working days of receipt

2.7.2.3 AAH will pay or deny 99% of clean claims within 90 calendar days of receipt

2.7.4 PMPM payments will be provided for applicable CS services (e.g., housing).

2.8 Restrictions and Limitations

2.8.1 Community Supports are alternative services to covered benefits under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered by AAH if: 1) the State determines they are medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the Community Supports and 3) the Community Supports is authorized and identified in the AAH managed care plan contracts.

2.8.2 This service is covered for a duration of less than 24 hours.

2.8.3 AAH will ensure that individuals are not receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.9 Discontinuing Services

2.9.1 Discontinuing of CS services will be based on:

2.9.1.1 Goals met/improved health status

2.9.1.2 Termination of coverage

2.9.1.3 No longer meets criteria

2.9.1.4 Member/caregiver declines services

2.9.1.5 Death of member

2.9.2 CS Providers will submit monthly reports identifying AAH members who have

completed the CS service.

2.9.3 AAH will perform case closure and CS service disenrollment in the Clinical Information System.

2.10 Licensing / Allowable Providers

2.10.1 AAH may choose to manage these services directly, coordinate with an existing Medi-Cal provider to manage the services, and/or contract with a county agency, community-based organization, or other organization, as needed. The services will be provided in conjunction with culturally and linguistically competent means appropriate for Respite Care.

2.10.2 AAH CS Providers must have experience and expertise with providing these unique services.

2.10.3 AAH will apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. AAH will monitor the provision of all the services included above.

2.10.3.1 CS Providers must be approved by AAH to ensure adequate experience and appropriate quality of care standards are maintained.

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2.10.5 AAH network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 22-013) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, AAH will credential the providers as required by DHCS.

DEFINITIONS / ACRONYMS

CS	Community Supports

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics
Member Services
Provider Services
Finance
Claims

RELATED POLICIES AND PROCEDURES

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REVISION HISTORY

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https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

MONITORING

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POLICY AND PROCEDURE

Policy Number	CS-013
Policy Name	Community Supports – Sobering Centers
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	TBD
Approval/Revision Date	TBD

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PROCEDURE

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UM-057 Authorization Service Request

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Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	~~HCS-015~~CM-0XX
Policy Name	Enhanced Care Management – Outreach/Member Engagement
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	`Quality Improvement Health Equity Committee
Subcommittee Approval Date	`8/18/2023
Approval/Revision Date	~~12/19/2023~~TBD

POLICY STATEMENT

AAH is responsible for engaging Enhanced Care Management (ECM) eligible members, using state determined, Centers for Medicare & Medicaid Services (CMS) approved criteria.

PROCEDURE

~~1.~~ AAH links ECM members to one of our contracted ECM Providers.

1.

1.1.1 If the ECM member's assigned primary care provider (PCP) is affiliated with an ECM Provider, the ECM member will be assigned to that ECM Provider, unless the member chooses another ECM Provider or a more appropriate ECM Provider is identified given the member's individual needs and conditions.

1.1.2 AAH and/or the ECM Provider's notification will inform the ECM member that they are eligible for ECM services and will identify both AAH and the ECM Provider. This notification will explain that ECM participation is voluntary, members have the opportunity to choose a different ECM Provider, and ECM members can discontinue participation at any time. It will also explain the process for participation. ~~In Alameda County, the ECM member may change their health plan once per month in accordance with current health plan choice policies.~~

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~~2.~~ AAH has the ability to perform the following duties/responsibilities or delegate to ECM Providers and provide appropriate oversight.

2.

1.2.1 AAH has the capacity to engage and provide services to eligible members, including:

1.2.1.1 Develop an ECM eligibility list including HHP/WPC enrolled members transitioning to ECM or HHP/WPC eligible members actively being outreached by ECM Providers transitioning to ECM;

1.2.1.2 Review the members on the eligibility list for homelessness;

1.2.1.3 Attribute eligible ECM members to ECM Providers. (See CM- 010 Enhanced Care Management: Member Identification, Grouping & Eligibility List Management);

1.2.1.4 When possible, refer eligible members known to be homeless to ECM Providers with expertise in outreach/engagement of people experiencing homelessness;

1.2.1.5 For homeless members assigned to ECM Providers without expertise in outreaching people who are homeless, AAH will attempt to coordinate support from street outreach or other homeless service providers;

1.2.1.6 Ensure attempts at the engagement of members on the ECM Eligibility List;

1.2.1.7 Secure and maintain record of the member's consent to participate in the program (which can be verbal); and

1.2.1.8 Provide member resources (e.g. customer service, member grievance process) relating to ECM.

1.2.2 AAH has the ability to engage members or delegate proper engagement processes to ECM Providers, including:

1.2.2.1 Identifying, locating, and engaging ECM-eligible members. AAH uses a model outreach protocol as the primary guidance to ECM Providers ~~and to internal ECM staff~~ in locating and engaging members.

3. The number of contacts and usual progression of steps for various modalities includes five attempts to contact the member within 90 days after the ECM Provider receives the ECM Eligibility List. Outreach efforts will consist of:

~~a.~~ 1.3.1 Assigned Members in High Tier will receive a minimum of every other week outreach contacts/attempts.

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~~b.~~1.3.2 Assigned Members in Low Tier will receive a minimum of monthly outreach contacts/attempts.

~~c.~~1.3.3 All attempts to contact will be documented within the ECM Provider's care management record system.

~~1.3.1~~1.3.4 Active outreach strategies may include but not be limited to:

~~a.~~1.3.4.1 Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts;

~~b.~~1.3.4.2 Direct communications with Members by letter, email, social media, texts, telephone;

~~c.~~1.3.4.3 Outreach to care delivery and social service partners, providers in the AAH network, and/or specific AAH personnel, to obtain information to help locate and contact the Member; and/or

~~d.~~1.3.4.4 When possible, available data exchange platform to obtain information to help locate and contact the Member; and/or

~~e.~~1.3.4.5 Outreach to SNF's and inpatient facilities. The MCP will share ADT feeds and census information with ECM Providers to help direct this outreach;

~~f.~~1.3.4.6 Street level outreach to hold face-to-face meetings at community settings, where the Member lives and/or where the Member seeks care or is otherwise accessible.

1.3.5 Active outreach strategies will be done primarily through in-person contact. Active, meaningful and progressive attempts at member engagement must be shown each month until the member is engaged. Activities that support member engagement include active outreach such as direct communications with member (face to face, mail, email, telephone), follow up if the member presents to another partner agency or facility in the ECM network or if able to contact through teleconferencing or telehealth services, or using claims data to identify and contact providers the member is known to use. Examples of acceptable engagement include:

~~1.3.2~~

~~1.3.2.1~~1.3.5.1 If member ~~prefers~~ prefers and is available, teleconferencing may be used. Due to public health restrictions, telehealth, teleconferencing could be used to supplement in-person contact.

~~1.3.2.2~~1.3.5.2 Letter to member followed by phone call to member.

~~1.3.2.3~~1.3.5.3 Phone call to member, outreach to care delivery partners and social service partners.

~~1.3.2.4~~1.3.5.4 Street level outreach, including, but not limited to, where the member lives or is accessible.

~~1.3.2.5~~1.3.5.5 After five (5) unsuccessful attempts, the ECM Provider and the MCP will note and document the challenges with the active outreach and ask the PCP to discuss ECM with the member at the next PCP visit.

~~1.3.2.5.1~~1.3.5.5.1 If the member declines ECM enrollment at the PCP visit, this will be noted in the ECM Provider's system of record and the MCP will be notified.

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~~1.3.2.5.2~~1.3.5.5.2 If the ECM Provider or the MCP learns that the member contact information is out of date, efforts will be made to update that information using recent provider records and community health workers who can conduct on-the-ground outreach to locate members through their neighbors or community organizations.

~~1.3.2.5.3~~1.3.5.5.3 For members who are homeless, the ECM provider will also review members' housing and utilization history and work with the MCP and appropriate County agencies to determine if that member can be reached at a shelter, alternative housing site or through a community-based organization.

~~1.3.2.6~~1.3.5.6 Establish a process for reviewing and excluding people from the ECM Eligibility list. Those members to be excluded are the following:

~~a.~~1.3.5.6.1 Members whose condition management cannot be improved because the member is uncooperative;

~~b.~~1.3.5.6.2 Members whose behavior or environment is unsafe for ECM staff;

~~c.~~1.3.5.6.3 Members determined to be more appropriate for an alternate care management program;

~~d.~~1.3.5.6.4 Members receiving hospice care;

~~e.~~1.3.5.6.5 Members receiving pediatric palliative care;

~~f.~~1.3.5.6.6 Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month;

~~g.~~1.3.5.6.7 Members enrolled in any other program deemed to have duplication of care management/care coordination services;

~~h.~~1.3.5.6.8 Duplicated Targeted Case Management services (excluding Severe Mental Illness TCM);

~~i.~~1.3.5.6.9 Members determined through further assessment to be sufficiently well-managed through self-management, or through another program, or the member is otherwise determined to not fit the high-risk eligibility criteria. AAH deems members as "well-managed" based upon graduation criteria, i.e. whether the HAP goals have been met; whether the patient was linked with supportive or community services and feels as though there has been improvement; whether the patient has been linked with a housing referral and plan for monitoring if the member is experiencing homeless, and finally, whether there has been evidence of decreasing utilization of emergency services.

~~1.3.2.7~~1.3.5.7 Report Members determined not appropriate for ECM, along with a reason code, to DHCS.

~~1.3.2.8~~1.3.5.8 DHCS will evaluate AAH-enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the ECM Eligibility list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.

~~1.3.2.9~~1.3.5.9 Include housing navigators in the engagement process, at AAH's discretion.

~~1.3.2.10~~1.3.5.10 Document the member engagement process.

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~~1.3.2.11~~1.3.5.11 Develop a methodology and criteria used by AAH or the ECM Provider to stratify high, low need members.

~~1.3.2.12~~1.3.5.12 Develop educational materials or scripts to engage the member.

~~1.3.2.13~~1.3.5.13 Have policies and procedures to provide culturally appropriate communications and information that meet health literacy and trauma informed care standards.

~~1.3.2.14~~1.3.5.14 Have policies and procedures for the following:

~~1.3.2.14.1~~1.3.5.14.1 Required number and modalities of attempts made to engage member AAH's protocol for follow up attempts.

~~1.3.2.14.2~~1.3.5.14.2 AAH's protocol for discharging members who cannot be engaged, choose not to participate, or fail to participate.

~~1.3.3~~1.3.6 After AAH has screened people who are inappropriate for ECM from the ECM Eligibility list based on the ECM requirements, AAH will create a priority engagement group, or ranking process, with the goal of engaging and serving members who present the greatest opportunity for improvement in care management and reduction in avoidable utilization.

~~1.3.3.1~~1.3.6.1 This group, or members in order or priority rank, would be the first focus for AAH engagement efforts. The criteria and size of the group for priority engagement status will be at AAH's discretion.

DEFINITIONS / ACRONYMS

ECM – Enhanced Care Management
AAH – Alameda Alliance for Health
SNF – Skilled Nursing Facility
DHCS – Department of Health Care Services
PCP – Primary Care Provider
MCP – Managed Care Plan
ADT – Admission Discharge Transfer

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing

CM-018 Enhanced Care Management – Member Notification
~~HCS-020~~CM-037 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 12/19/2023

REFERENCES

California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

Lease

POLICY AND PROCEDURE

Policy Number	CM-0XX
Policy Name	Enhanced Care Management – Outreach/Member Engagement
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Medical Director
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	`Quality Improvement Health Equity Committee
Subcommittee Approval Date	`8/18/2023
Approval/Revision Date	TBD

POLICY STATEMENT

AAH is responsible for engaging Enhanced Care Management (ECM) eligible members, using state determined, Centers for Medicare & Medicaid Services (CMS) approved criteria.

PROCEDURE

1. AAH links ECM members to one of our contracted ECM Providers.

1.1.1 If the ECM member's assigned primary care provider (PCP) is affiliated with an ECM Provider, the ECM member will be assigned to that ECM Provider, unless the member chooses another ECM Provider or a more appropriate ECM Provider is identified given the member's individual needs and conditions.

1.1.2 AAH and/or the ECM Provider's notification will inform the ECM member that they are eligible for ECM services and will identify both AAH and the ECM Provider. This notification will explain that ECM participation is voluntary, members have the opportunity to choose a different ECM Provider, and ECM members can discontinue participation at any time. It will also explain the process for participation.

2. AAH has the ability to perform the following duties/responsibilities or delegate to ECM Providers and provide appropriate oversight.

1.2.1 AAH has the capacity to engage and provide services to eligible members, including:

1.2.1.1 Develop an ECM eligibility list including HHP/WPC enrolled members transitioning to ECM or HHP/WPC eligible members actively being outreached by ECM Providers transitioning to ECM;

1.2.1.2 Review the members on the eligibility list for homelessness;

1.2.1.3 Attribute eligible ECM members to ECM Providers. (See CM- 010 Enhanced Care Management: Member Identification, Grouping & Eligibility List Management);

1.2.1.4 When possible, refer eligible members known to be homeless to ECM Providers with expertise in outreach/engagement of people experiencing homelessness;

1.2.1.5 For homeless members assigned to ECM Providers without expertise in outreaching people who are homeless, AAH will attempt to coordinate support from street outreach or other homeless service providers;

1.2.1.6 Ensure attempts at the engagement of members on the ECM Eligibility List;

1.2.1.7 Secure and maintain record of the member's consent to participate in the program (which can be verbal); and

1.2.1.8 Provide member resources (e.g. customer service, member grievance process) relating to ECM.

1.2.2 AAH has the ability to engage members or delegate proper engagement processes to ECM Providers, including:

1.2.2.1 Identifying, locating, and engaging ECM-eligible members. AAH uses a model outreach protocol as the primary guidance to ECM Providers in locating and engaging members.

3. The number of contacts and usual progression of steps for various modalities includes five attempts to contact the member within 90 days after the ECM Provider receives the ECM Eligibility List. Outreach efforts will consist of:

1.3.1 Assigned Members in High Tier will receive a minimum of every other week outreach contacts/attempts.

1.3.2 Assigned Members in Low Tier will receive a minimum of monthly outreach contacts/attempts.

1.3.3 All attempts to contact will be documented within the ECM Provider's care management record system.

1.3.4 Active outreach strategies may include but not be limited to:

1.3.4.1 Reviewing Provider schedules and flagging those scheduled with an appointment with their PCP for face-to-face engagement efforts;

1.3.4.2 Direct communications with Members by letter, email, social media, texts, telephone;

1.3.4.3 Outreach to care delivery and social service partners, providers in the AAH network, and/or specific AAH personnel, to obtain information to help locate and contact the Member; and/or

1.3.4.4 When possible, available data exchange platform to obtain information to help locate and contact the Member; and/or

1.3.4.5 Outreach to SNF's and inpatient facilities. The MCP will share ADT feeds and census information with ECM Providers to help direct this outreach;

1.3.4.6 Street level outreach to hold face-to-face meetings at community settings, where the Member lives and/or where the Member seeks care or is otherwise accessible.

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1.3.5.8 DHCS will evaluate AAH-enrolled vs non-enrolled members and compare across MCPs for general compliance review purposes and to ensure that the engagement process is adequately engaging members on the ECM Eligibility list who are at the highest risk levels, have behavioral health conditions, and those experiencing homelessness.

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AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls
CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
CM-037 Enhanced Care Management – IT/Data Sharing

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 12/19/2023

REFERENCES

California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Control

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	~~HCS-020~~CM-0XX
Policy Name	Enhanced Care Management – IT/Data Sharing
Department Name	Information Technology
Department Officer	Chief Medical Officer
Policy Owner	Director, SDOH
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	~~9/19/2023~~TBD

POLICY STATEMENT

This policy describes how information is shared across the entire care team for the Enhanced Care Management (ECM) Program, including the member, the ECM Provider, Primary Care Providers (PCPs) and Alameda Alliance for Health (AAH). It addresses all of the following elements of provision of care including: Comprehensive Care Management, Care Coordination and Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Support Services.

PROCEDURE

1.0 Comprehensive Care Management

1.1 Identify cohort and integrate risk stratification information.

1.2 Member Identification: See CM-010 Enhanced Care Management – Member Identification and Grouping.

1.3 Shared Care Plan Management

1.3.1 The Health Action Plan (HAP) is a combination of the ECM Assessment and the resultant Care Plan. The combination is known as the HAP. The HAP is accessible to all members of the care team at the ECM Provider via their internal system of record and to AAH via fax or secure email. If the ECM Provider needs to share with an external PCP, then that sharing would be through either fax, secure email or postal mail:

1.3.1.1 The Member will be provided, upon request, a copy of the HAP by mail or in person and updates provided during each follow up.

1.3.1.2 The PCP will be given the Member's HAP.
1.3.1.3 Other ECM Provider care team members have access to the HAP and have the ability to update and modify the HAP.

1.4 The ECM Provider reviews the HAP with each Member and will reassess and update it with any changes in the Member's progress, status, or health care needs and/or according to the HAP follow up plan and at least quarterly.

1.4.1 A care team member reviews utilization reports identifying a Member who has had a recent hospital admission or discharge or Emergency Department (ED) visit. This will alert them to contact the Member as appropriate, to review the current HAP and make changes as necessary.

1.4.2 ECM Provider team member reviews the HAP with the Member at each contact to assess the progress made towards the goals identified in the HAP as well as tracks referrals made and follow-up on completion and communication on each referral.

1.4.3 The ECM Provider will make updates to the HAP if a goal has changed priority, has been met or is no longer applicable.

1.5 The HAP will be completed within ninety (90) days of ECM enrollment.

1.6 Clinical decision support tools to ensure appropriate care is delivered.

1.6.1 Medical Directors and Nurses use Milliman Care Guidelines (MCG) for clinical review and to conduct advisor reviews/make decisions. AAH's clinical management team uses "Up-To-Date" tools to ensure all clinical decisions are made appropriately.

1.6.2 Additional data exchange solutions within AAH to facilitate care management and safe transitions of care include the following:

1.6.2.1 Daily census file delivered to each ECM Provider (admissions of enrolled and eligible members).

1.6.2.2 Communication from inpatient UM (concurrent review) team members and case managers to ECM Providers.

1.6.2.3 Additionally, AAH is in the process of updating its Admission, Discharge, Transfer (ADT) feeds to improve the quality and accuracy of our reporting.

1.6.2.4 When available, a data exchange platform.

1.6.3 Electronic capture of clinical quality measures to support quality improvement.

1.6.3.1 Utilization Management (UM) Nurses utilize MCG and Medi-Cal Guidelines for clinical review and MDs conduct advisor reviews/decisions. Inter-rater reliability (IRR) is conducted on an annual basis for UM nurses and Medical Directors.

2.0 Care Coordination and Health Promotion

2.1 Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.

2.1.1 Patient-centered care is not electronically captured at present. AAH Information Technology (IT) has been working with the ECM program staff to receive HAP data from ECM Provider systems and will load them into the AAH medical management system which can be used for patient-

centric care. In the interim, HAPs will be shared, as needed, though fax.

2.2 Tools to support shared decision-making approaches with patients. The ECM Providers, with the coordination of the managed care plan, shall make shared decision(s) on patients care coordination.

2.2.1 AAH uses the following tools to help support the recommendations for care: The HAP, updated quarterly, is accessible to all members of the care team at the ECM Provider via their internal system of record and to AAH via fax or secure email. If the ECM Provider needs to share with an external PCP, then that sharing would be through either fax or postal mail. In addition, UM Nurses utilize MCG and Medi-Cal Guidelines for clinical review and MDs conduct advisor reviews/decisions. Inter-rater reliability (IRR) is conducted on an annual basis for UM nurses and MDs.

2.3 Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.

2.3.1 Presently, all information sharing by AAH with members occurs via phone and letter.

2.4 Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.

2.4.1 E-prescribing, drug formulary checks, and medication reconciliation are managed by ECM Providers. AAH shall provide patient claims data to ECM Providers, and they internally will have a process to check the drug formulary, e-prescribing, and medication reconciliation.

2.5 Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.

2.5.1 Current member portal allows patients to view their claims, eligibility, and provider information. AAH has a customer service call center where patients can call and update their own health information.

2.6 Telehealth services including remote patient monitoring

2.6.1 Telehealth services are available only through the ECM Provider sites. The ECM team acting as an ECM Provider will not provide telehealth services but rather work with the member's assigned PCP or Specialist who will provide telehealth services.

3.0 Comprehensive Transitional Care

3.1 Automated care transition notifications/alerts, e.g., when a patient is discharged from the hospital or receives care in an ED. Include other methods if an electronic process is not used (Fax, Email, Texts, Telephone Calls). Additionally, ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the Electronic Health Record (her). Include other methods if electronic sharing is not used.

3.1.1 Daily census file delivered to each ECM Provider (admissions of enrolled and eligible members).

3.1.2 Communication from inpatient UM (concurrent review) team members and case managers to ECM Providers.

3.1.3 Additionally, AAH is in the process of updating its ADT feeds to improve the quality and accuracy of our reporting. AAH receives a real-time electronic ADT feed from several hospitals.

3.1.4 In partnership with Alameda County's Health Care Services Agency

(HCSA), AAH has given ECM Providers access to Alameda County's Community Health Record (CHR) platform. The CHR launched in Fall 2019. The CHR serves as an ADT feed and a shared social and health information exchange to facilitate care management, care coordination, and safe transitions.

3.2 Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

3.2.1 E-referrals and e-consults are done by the ECM Providers in coordination with AAH.

4.0 Individual and Family Support Services

4.1 Patient specific education resources tailored to specific conditions and needs.

4.1.1 Patient specific education resources are customized by the ECM Provider and in coordination with AAH.

5.0 Referral to Community and Social Support Services

5.1 Electronic capture of social, psychological, and behavioral data (e.g., education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.

5.1.1 AAH relies on external sources to provide data. At this time, this capability is not automated.

5.2 Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used. All patient referrals are done by the ECM Provider.

6.0 Encounter Data

6.1 AAH can collect and transmit encounter data for ECM Providers in the X12 837 or paper format or online submission. All electronic transmission occurs in secure format via Secure File Transfer Protocol (SFTP).

6.2 If there are continuous errors in an ECM Provider's data submission, AAH will develop a Corrective Action Plan (CAP) for the ECM Provider.

DEFINITIONS / ACRONYMS

AAH	Alameda Alliance for Health
ECM	Enhanced Care Management
HAP	Health Action Plan

AFFECTED DEPARTMENTS/PARTIES

Information Technology
Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
~~HCS-015~~CM-036 Enhanced Care Management – Outreach/Member Engagement

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 9/19/2023

REFERENCES

California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

POLICY AND PROCEDURE

Policy Number	CM-0XX
Policy Name	Enhanced Care Management – IT/Data Sharing
Department Name	Information Technology
Department Officer	Chief Medical Officer
Policy Owner	Director, SDOH
Line(s) of Business	Medi-Cal
Effective Date	05/16/2019
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	8/18/2023
Compliance Committee Approval Date	TBD

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1.2 Member Identification: See CM-010 Enhanced Care Management – Member Identification and Grouping.

1.3 Shared Care Plan Management

1.3.1 The Health Action Plan (HAP) is a combination of the ECM Assessment and the resultant Care Plan. The combination is known as the HAP. The HAP is accessible to all members of the care team at the ECM Provider via their internal system of record and to AAH via fax or secure email. If the ECM Provider needs to share with an external PCP, then that sharing would be through either fax, secure email or postal mail:

1.3.1.1 The Member will be provided, upon request, a copy of the HAP by mail or in person and updates provided during each follow up.

1.3.1.2 The PCP will be given the Member's HAP.
1.3.1.3 Other ECM Provider care team members have access to the HAP and have the ability to update and modify the HAP.

1.4 The ECM Provider reviews the HAP with each Member and will reassess and update it with any changes in the Member's progress, status, or health care needs and/or according to the HAP follow up plan and at least quarterly.
1.4.1 A care team member reviews utilization reports identifying a Member who has had a recent hospital admission or discharge or Emergency Department (ED) visit. This will alert them to contact the Member as appropriate, to review the current HAP and make changes as necessary.
1.4.2 ECM Provider team member reviews the HAP with the Member at each contact to assess the progress made towards the goals identified in the HAP as well as tracks referrals made and follow-up on completion and communication on each referral.
1.4.3 The ECM Provider will make updates to the HAP if a goal has changed priority, has been met or is no longer applicable.

1.5 The HAP will be completed within ninety (90) days of ECM enrollment.

1.6 Clinical decision support tools to ensure appropriate care is delivered.

1.6.1 Medical Directors and Nurses use Milliman Care Guidelines (MCG) for clinical review and to conduct advisor reviews/make decisions. AAH's clinical management team uses "Up-To-Date" tools to ensure all clinical decisions are made appropriately.
1.6.2 Additional data exchange solutions within AAH to facilitate care management and safe transitions of care include the following:
1.6.2.1 Daily census file delivered to each ECM Provider (admissions of enrolled and eligible members).
1.6.2.2 Communication from inpatient UM (concurrent review) team members and case managers to ECM Providers.
1.6.2.3 Additionally, AAH is in the process of updating its Admission, Discharge, Transfer (ADT) feeds to improve the quality and accuracy of our reporting.
1.6.2.4 When available, a data exchange platform.
1.6.3 Electronic capture of clinical quality measures to support quality improvement.
1.6.3.1 Utilization Management (UM) Nurses utilize MCG and Medi-Cal Guidelines for clinical review and MDs conduct advisor reviews/decisions. Inter-rater reliability (IRR) is conducted on an annual basis for UM nurses and Medical Directors.

2.0 Care Coordination and Health Promotion

2.1 Ability to electronically capture and share the patient-centered care plan across care team members. Include other methods if electronic means of collection are not used.
2.1.1 Patient-centered care is not electronically captured at present. AAH Information Technology (IT) has been working with the ECM program staff to receive HAP data from ECM Provider systems and will load them into the AAH medical management system which can be used for patient-

centric care. In the interim, HAPs will be shared, as needed, though fax.

2.2 Tools to support shared decision-making approaches with patients. The ECM Providers, with the coordination of the managed care plan, shall make shared decision(s) on patients care coordination.

2.2.1 AAH uses the following tools to help support the recommendations for care: The HAP, updated quarterly, is accessible to all members of the care team at the ECM Provider via their internal system of record and to AAH via fax or secure email. If the ECM Provider needs to share with an external PCP, then that sharing would be through either fax or postal mail. In addition, UM Nurses utilize MCG and Medi-Cal Guidelines for clinical review and MDs conduct advisor reviews/decisions. Inter-rater reliability (IRR) is conducted on an annual basis for UM nurses and MDs.

2.3 Secure electronic messaging between providers and patients to increase access outside of office encounters. Include other methods if electronic messaging is not used.

2.3.1 Presently, all information sharing by AAH with members occurs via phone and letter.

2.4 Medication management tools including e-prescribing, drug formulary checks, and medication reconciliation.

2.4.1 E-prescribing, drug formulary checks, and medication reconciliation are managed by ECM Providers. AAH shall provide patient claims data to ECM Providers, and they internally will have a process to check the drug formulary, e-prescribing, and medication reconciliation.

2.5 Patient portal services that allow patients to view and correct their own health information. Include other methods if an electronic system is not used.

2.5.1 Current member portal allows patients to view their claims, eligibility, and provider information. AAH has a customer service call center where patients can call and update their own health information.

2.6 Telehealth services including remote patient monitoring

2.6.1 Telehealth services are available only through the ECM Provider sites. The ECM team acting as an ECM Provider will not provide telehealth services but rather work with the member's assigned PCP or Specialist who will provide telehealth services.

3.0 Comprehensive Transitional Care

3.1 Automated care transition notifications/alerts, e.g., when a patient is discharged from the hospital or receives care in an ED. Include other methods if an electronic process is not used (Fax, Email, Texts, Telephone Calls). Additionally, ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the Electronic Health Record (her). Include other methods if electronic sharing is not used.

3.1.1 Daily census file delivered to each ECM Provider (admissions of enrolled and eligible members).

3.1.2 Communication from inpatient UM (concurrent review) team members and case managers to ECM Providers.

3.1.3 Additionally, AAH is in the process of updating its ADT feeds to improve the quality and accuracy of our reporting. AAH receives a real-time electronic ADT feed from several hospitals.

3.1.4 In partnership with Alameda County's Health Care Services Agency

(HCSA), AAH has given ECM Providers access to Alameda County's Community Health Record (CHR) platform. The CHR launched in Fall 2019. The CHR serves as an ADT feed and a shared social and health information exchange to facilitate care management, care coordination, and safe transitions.

3.2 Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.

3.2.1 E-referrals and e-consults are done by the ECM Providers in coordination with AAH.

4.0 Individual and Family Support Services

4.1 Patient specific education resources tailored to specific conditions and needs.

4.1.1 Patient specific education resources are customized by the ECM Provider and in coordination with AAH.

5.0 Referral to Community and Social Support Services

5.1 Electronic capture of social, psychological, and behavioral data (e.g., education, stress, depression, physical activity, alcohol use, social connection and isolation, exposure to violence). Include other methods if electronic means of collection are not used.

5.1.1 AAH relies on external sources to provide data. At this time, this capability is not automated.

5.2 Ability to electronically refer patients to necessary services. Include other methods if electronic referral is not used. All patient referrals are done by the ECM Provider.

6.0 Encounter Data

6.1 AAH can collect and transmit encounter data for ECM Providers in the X12 837 or paper format or online submission. All electronic transmission occurs in secure format via Secure File Transfer Protocol (SFTP).

6.2 If there are continuous errors in an ECM Provider's data submission, AAH will develop a Corrective Action Plan (CAP) for the ECM Provider.

DEFINITIONS / ACRONYMS

AAH Alameda Alliance for Health
ECM Enhanced Care Management
HAP Health Action Plan

AFFECTED DEPARTMENTS/PARTIES

Information Technology
Health Care Services
Analytics

RELATED POLICIES AND PROCEDURES

CM-009 Enhanced Care Management – Infrastructure
CM-010 Enhanced Care Management – Member Identification and Grouping
CM-011 Enhanced Care Management – Care Management & Transitions of Care
CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

CM-0XX Enhanced Care Management– IT/Data Sharing

CM-014 Enhanced Care Management – Operations Non-Duplication
CM-016 Enhanced Care Management – Staffing
CM-018 Enhanced Care Management – Member Notification
CM-036 Enhanced Care Management – Outreach/Member Engagement

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

N/A

REVISION HISTORY

05/20/2021, 01/20/2022, 03/22/2022, 9/19/2023

REFERENCES

California Advancing & Innovating Medi-Cal (CalAIM) Proposal February 2021

MONITORING

CM-013 Enhanced Care Management – Oversight, Monitoring, & Controls

POLICY AND PROCEDURE

Policy Number	UM-001
Policy Name	Utilization Management Program
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	~~Sr. Director, Health Care Services~~Director of Utilization Management
Line(s) of Business	Medi-Cal, Group Care
Effective Date	11/02/2004
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	~~5/19/2023~~TBD
Compliance Committee Approval Date	~~6/20/2023~~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 Committee (QIHEC) 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 QIHEC 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 Committee (QIHEC,) 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 Committee (QIHEC,) and the Board of Governors, (BOG.)

V. The Alliance UM program shall include the following elements:

a. Authorization is not required prior to the provision of emergency services and care needed to stabilize a Member's emergent~~cy~~ medical condition.
b. The Alliance covers all emergency room services and does not deny any emergency room claims.
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.
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.
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:

    i. The Alliance distributes an affirmative statement to all practitioners, providers, staff, and members regarding incentives to ensure appropriate utilization and discourage underutilization.
    ii. The Alliance does not use incentives to encourage barriers to care and service.
    iii. The plan will ensure that a Medical Director's authorization decisions avoid any conflict of interest situations.

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~~P~~ policy and procedure for Second Opinion (UM-005).
g. The Alliance and its delegates will maintain evidence-based criteria and apply the~~a~~ UM ~~hierarchal~~ hierarchy criteria that was approved by the Alliance's UMC, ~~process~~ for approving, modifying, deferring, and denying requested services.

    i. The UM hierarch~~yal~~ criteria ~~process~~:

        1. Regulatory and contractual requirements
            - Regulatory requirements include WPATH guidelines for Transgender Care
            - Regulatory requirements include LOCUS/CALOCUS, CASII/ECSII/ASAM for Mental Health and Substance Use Disorders.
        2. Evidence based guidelines.
        3. Alliance specific guidelines
        4. National medical association consensus
        5. Independent Medical Review (UM-046)
        6. Medical necessity/medical judgment

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.
iii. Criteria are applied in conjunction with considering individual needs, such as:

1. Age
2. Co-morbidities
3. Complications
4. Progress of Treatment
5. Psychosocial situations, and
6. Home environment

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.

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 ca~~e~~a~~E~~ach l~~L~~evel and t~~T~~ype 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 Committee (QIHEC,)

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 ~~Manager~~ 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. Specialty Mental Health (SMHS)/Behavioral healthcare services for Medi-Cal Members are carved out to 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 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 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 both UMC and QIHEC 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 QIHEC 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.

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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~~within 90 days from the date of service~~ will be reviewed for medical necessity.
b. **Retrospective Authorization Review**: Submissions received up to ~~after~~ 90 days from the date of service will be reviewed for medical necessity.
~~b. .~~
c.
~~c.~~ **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~~ed~~ for not obtaining prior authorization. ~~Exceptions include member eligibility issues and if the services were emergent/urgent. If the exceptions are met, then the submission will be reviewed for medical necessity regardless of when it was received.~~
~~i.~~ **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. ~~Exceptions include member eligibility issues and post-stabilization care where the facility is unable to confirm enrollment with the Alliance due to extenuating~~

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~~circumstances. If the exceptions are met then the admission will be reviewed for medical necessity regardless of when it was received.~~

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.

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.

d. Exceptions for retrospective requests for non-emergent or non-urgent services that would require prior authorization ~~Exceptions~~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. ~~and if the services were emergent/urgent~~ (UM-057). ~~If the exceptions are met, then the submission will be reviewed for medical necessity regardless of when it was received.~~

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

1. 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. M~~m~~edical care provided meets the standard for acceptable medical care.
      ii. M~~m~~edical protocols and rules of conduct for plan medical personnel are followed.
   b. The Alliance and its delegates will ensure that medical decisions:
      i. A~~a~~re rendered by qualified medical personnel and
      ii. I~~i~~ncluding those by delegated entities and rendering Providers, are not unduly influenced by fiscal and administrative management.
      iii. T~~t~~o 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 ~~Services~~ manages:
   a. Services that allow direct access (services exempt from prior authorization)

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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. Pprior authorization and referral management
        2. Iinpatient concurrent review, discharge planning, and care management
        3. Rretrospective requests

c. ~~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, ~~and~~ targeted case management and Transitional Care Services.

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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 ddenial 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 ~~Processes for s~~Second Oopinions and are at no cost to the Medi-Cal Member
7. Processes for written notifications of determination through a Notice of Action Letter (NOA) to Providers and Members, 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:
    a. 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. 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 of a 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.
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

QI-101 Quality Improvement Program
UM-005 Second Opinions
UM-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 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, 04/19/2024

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)

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, reviews:
      i. Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
      ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
      iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
   b. Inter-R~~r~~ater 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 review without supervision.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-001
Policy Name	Utilization Management Program
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	Director of Utilization Management
Line(s) of Business	Medi-Cal, Group Care
Effective Date	11/02/2004
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	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 Committee (QIHEC) 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 QIHEC 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 Committee (QIHEC,) 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 Committee (QIHEC,) and the Board of Governors, (BOG.)

V. The Alliance UM program shall include the following elements:

a. Authorization is not required prior to the provision of emergency services and care needed to stabilize a Member's emergent medical condition.
b. The Alliance covers all emergency room services and does not deny any emergency room claims.
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.
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.
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:

    i. The Alliance distributes an affirmative statement to all practitioners, providers, staff, and members regarding incentives to ensure appropriate utilization and discourage underutilization.
    ii. The Alliance does not use incentives to encourage barriers to care and service.
    iii. The plan will ensure that a Medical Director's authorization decisions avoid any conflict of interest situations.

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)
g. The Alliance and its delegates will maintain evidence-based criteria and apply the UM hierarchy criteria that was approved by the Alliance's UMC, for approving, modifying, deferring, and denying requested services.

    i. The UM hierarchy criteria:

        1. Regulatory and contractual requirements
            - Regulatory requirements include WPATH guidelines for Transgender Care
            - Regulatory requirements include LOCUS/CALOCUS, CASII/ECSII/ASAM for Mental Health and Substance Use Disorders.
        2. Evidence based guidelines.
        3. Alliance specific guidelines
        4. National medical association consensus
        5. Independent Medical Review (UM-046)
        6. Medical necessity/medical judgment

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.
iii. Criteria are applied in conjunction with considering individual needs, such as:

1. Age
2. Co-morbidities
3. Complications
4. Progress of Treatment
5. Psychosocial situations, and
6. Home environment

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.

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 Committee (QIHEC,)

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. Specialty Mental Health (SMHS)/Behavioral healthcare services for Medi-Cal Members are carved out to 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 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 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 both UMC and QIHEC 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 QIHEC 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.
c.
d. **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.

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.
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.

e. 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

1. 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) to Providers and Members, 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:
    a. 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. 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 of a 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.

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    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.
13. **Member** means any eligible beneficiary who has enrolled in the AAH and who has been assigned to or selected AAH.
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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, reviews:
        i. Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
        iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
    b. Inter-Rater Reliability - At least annually 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 review without supervision.

POLICY AND PROCEDURE

Policy Number	UM-046
Policy Name	Use of Board -Certified Consultants
Department Name	Health Care Services
Policy Owner	Utilization Management Medical Director
Lines of Business	~~Medi-Cal and Group Care~~MCAL, IHSS
Effective Date	1/1/2012
Subcommittee Name	~~Health Care Quality Committee~~Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~8/18/2023~~TBD
Administrative Oversight Committee Approval Date	~~9/18/2023~~TBD

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POLICY STATEMENT

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 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 B~~b~~oard -C~~c~~ertified 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) 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 C-~~c~~ertified consultants is reviewed and updated annually to ensure compliant certification. This list and relevant contact information are in Attachment A – AMR Board Certified Consultants List.

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.

PROCEDURE

Section I. 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 Ceertified consultants will provide an independent medical review with medical necessity recommendations based on peer reviewed published journals, national organization guidelines, and expert opinion.
~~1.~~2. **High Complexity or Specialized Procedures and Services** – Board -Certified Consultants should be used to review highly complex procedures. These procedures or services require the review of a professional in the same or similar specialty to the physician performing the procedure.
~~2.~~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.
~~3.~~4. **-Conflict of Interest** – Board -Certified Consultants should be used if available internal reviewers have established personal or professional conflicts of interest.

Section II. How to Use a Board -Certified Consultant
1. The Alliance contracts with Advanced Medical Reviews (AMR) to provide independent medical review services, upon request, to support the inpatient and outpatient medical necessity service authorization decision process.
    a. Requests for an AMR ~~b~~Board -~~e~~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.
    c. Receive decision and supporting explanations within 24 hours of their receipt of initial case information.

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DEFINITIONS

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.

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 AND OTHER RELATED DOCUMENTS

PDR-001 Provider Dispute Resolution Mechanism
QI-104 Potential Quality of Care Issues (PQIs)

UM-001 Utilization Management Program~~Authorization Process~~
UM-046 –Attachment A

- AMR Board -Certified Consultants List

REVISION 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, 7/26/2024

REFERENCES

2012 NCQA Standards UM 4.E (Use of Board -Certified Consultants)

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~~care~~ Equity ~~Quality~~ Committee annually.

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-046
Policy Name	Use of Board Certified Consultants
Department Name	Health Care Services
Policy Owner	Utilization Management Medical Director
Lines of Business	MCAL, IHSS
Effective Date	1/1/2012
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Administrative Oversight Committee Approval Date	TBD

POLICY STATEMENT

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PROCEDURE

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- 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 AND OTHER RELATED DOCUMENTS

PDR-001 Provider Dispute Resolution Mechanism
QI-104 Potential Quality of Care Issues (PQIs)

UM-001 Utilization Management Program
UM-046 –Attachment A

- AMR Board Certified Consultants List

REVISION 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, 7/26/2024

REFERENCES

2012 NCQA Standards UM 4.E (Use of Board Certified Consultants)

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee annually.

POLICY AND PROCEDURE

Policy Number	CBAS-001
Policy Name	Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility
Department Name	OP UM
Department Officer	Chief Medical Officer
Policy Owner	~~Manager, OP UM~~Director Utilization Management
Line(s) of Business	Medi-Cal
Effective Date	10/01/2012
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	TBD~~5/19/2023~~
Compliance Committee Approval Date	TBD~~6/20/2023~~

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POLICY STATEMENT

The Alliance follows Department of Health Care Services (DHCS) specifications and guidance regarding initial determination of member eligibility for Community Based Adult Services (CBAS) as well as for periodic reassessments of eligibility determinations.

Alameda Alliance for Health (AAH) ensures the initial assessment and reassessment procedures for Members requesting CBAS, or who have previously been deemed eligible to receive CBAS, meet the following minimum requirements:

A. Ensures appropriate staff responsible for conducting, managing, and/or training for an initial assessment or reassessment of Members for CBAS is trained by DHCS on using the approved assessment tool.
B. Conducts the CBAS eligibility determination of a Member requesting CBAS using the assessment tool approved by DHCS. CBAS eligibility determinations include a face-to-face or Telephonic review of the Member. The assessment team includes a Registered Nurse with level of care experience, either as an employee or as a sub- contractor.
C. AAH shall reassess and re-determine the Member's eligibility for CBAS at least every six (6) months after initial assessment, or whenever a change in circumstances occurs that may require a change in the Member's CBAS benefit.
D. If Member is already receiving CBAS and requests that services remain at the same level or be increased due to a change in level of need, AAH may conduct the reassessment using only the Member's Individual Plan of Care (IPC), including any supporting documentation supplied by the CBAS Provider.

~~E. AAH shall not deny, defer, or reduce a requested level of CBAS for a Member without a face-to-face review performed by a Registered Nurse with level of care experience and utilizing the assessment tool approved by DHCS.~~

~~F.~~E. AAH shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in Exhibit A, Attachment 13, Provision 8, Denials, Deferrals, or Modifications of Prior Authorization Requests. AAH's written notice shall be approved by DHCS and include procedures for grievances and appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6, (Member Grievance and Appeal System.)

~~G.~~F. AAH shall require that CBAS Providers complete a CBAS Discharge Plan of Care for any Members who have been determined to no longer need CBAS.

PROCEDURE

The Alliance Out of Plan team receives a CBAS-interest call from the following sources:

- Self, family and/or caregiver
- Primary Care Provider (PCP)
- Alliance internal departments: such as the Intake Unit, Case Management, Member Services Unit and/or Utilization Management
- CBAS provider/center
- Home or Community-Based Organization (HCBO)
- Acute care hospital (see LTS-CBAS 0002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility)
- Skilled nursing facility, acute-care facility (see LTS-CBAS 0002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility)

The Alliance CBAS Out of Plan RN contacts the member/authorized representative to confirm interest in CBAS services and ascertain administrative eligibility. If member does not meet administrative criteria, a letter is sent informing the member and requester that the member did not meet minimum qualifications. Information regarding the rights to file a Grievance and Appeal, Independent Medical Review (IMR) and/or a State Fair Hearing is also sent to the member.

If the member meets administrative eligibility, the Alliance ensures that the member is in touch with the CBAS center of their choice, either through direct contact initiated by the member or through care coordination provided by an Alliance CBAS Out of Plan RN in order to initiate a site visit. If the member cannot make a choice of center, an Alliance CBAS team helps the member select a CBAS center that fits the member's interest, culture and language, health condition and/or geographic location. The Alliance works with the chosen or assigned CBAS center and the member's PCP to obtain medical necessity for CBAS services. Once medical necessity is obtained from the member's PCP, the CBAS center sends a referral to the Alliance for eligibility determination.

When the Alliance receives a referral for eligibility determination the following processes occur, although the ordering of the processes may vary according to individual cases:

1. Alliance CBAS team receives initial referral of a member to CBAS.

i. The Alliance acknowledges initial referral in writing to CBAS provider and to member within five (5) calendar days of initial referral.

ii. Out of Plan RN makes first attempt to schedule Face-to-Face assessment within 5 calendar days of initial referral.

   a. the RN makes two additional attempts via telephone to schedule between five (5) and eight (8) calendar days of initial referral

   b. If the RN is unable to contact the member and/or authorized representative by phone within eight (8) calendar days of the initial referral request, s/he makes final attempt in writing, giving the member until day 14 from initial referral to schedule face-to-face or Telephonic.

   c. If a member does not schedule within 14 days from initial referral, the Alliance will send a follow-up letter to member and requester informing them that if services are still needed, a new referral must be submitted to begin the process again.

iii. When an Alliance nurse successfully contacts the member and/or the authorized representative, the nurse confirms:

   a. Appropriateness of the referral, i.e., that the member meets the minimum qualifications.

3. An Alliance Registered Nurse with level of care experience arranges for a face-to-face interview with the member within 30 days from initial referral, employing the approved CBAS Eligibility Determination Tool (CEDT) (See Attachment A).

4. Plan staff, including RN Case Manager, approve or deny CBAS services based on information collected during the face-to-face assessment.

i. Denial of CBAS program:

   a. Member does not meet medical necessity criteria or member's need for services is not supported by CEDT.

   b. A denial of CBAS eligibility results in a Notice of Action (NOA,) which is sent to the member along with information on her/his right to file a Grievance and Appeal, Independent Medical Review and a State Fair Hearing. The CBAS provider also receives a copy of this letter. This letter is sent within five (5) working days of the face-to-face assessment.

   c. Grievance and Appeals

      - A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
      - A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

ii. Approval of CBAS program:

   a. Eligibility determination is communicated to the member and her/his

authorized representative within two ~~one~~ (2~~1~~) business days.

b. Authorization to conduct Individual Plan of Care (IPC) is communicated to the member's chosen CBAS provider within one (1) business day of the decision.

At this point, the CBAS provider is authorized to conduct a three (3) day multidisciplinary team assessment in order to produce an IPC, within 90 days.

5. CBAS center staff:

i. Performs three (3) day multidisciplinary team assessment.

ii. Based on the assessment, the CBAS center submits an Individualized Plan of Care (IPC) with level of service recommendation

iii. Submits a Prior Authorization request to the Alliance.

6. The Alliance:

i. Approves, modifies, or denies prior authorization request within five (5) business days in accordance with the standards set in the Health and Safety Code section 1367.01.

a. If the Alliance cannot make a decision within five (5) working days of receiving the authorization, the decision may be deferred, and the time limit may be extended no longer than 14 calendar days from the initial receipt of the authorization request. A deferral letter explaining the decision-making extension period is sent to the member and CBAS provider.

b. If a prior authorization request is denied or level of service is decreased (modified), a Notice of Action is sent to the member within 48 hours of decision, along with information on their rights to file a Grievance and Appeal, ~~i~~Independent Medical R~~r~~eview, and State Fair Hearing. The CBAS provider also receives a copy of this letter. The CBAS provider is notified within 1 Business Day~~24 hours~~.

c. Grievance and Appeals

- A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
- A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

ii. Approved services are authorized for a six-month period.

a. Member is notified within 2 Business Days~~48 hours~~ of authorization.

b. Center is notified within 1 Business Day~~24 hours~~ of authorization.

7. Reassessment: In order for CBAS services to continue, the CBAS center sends a prior authorization request including an updated IPC with level of service recommendations to the Alliance prior to the expiration of the authorized six-month period.

i. A reassessment and redetermination of a member's eligibility for CBAS is completed at least every six (6) months after the initial assessment or whenever a change in circumstances occurs that may require a change in the member's CBAS benefit.

ii. If a member is already receiving CBAS services and requests that services remain at the same level or be increased due to a change in level of need, the Alliance conducts the reassessment using only the member's IPC and any supporting documentation supplied by the CBAS Provider.

iii. Reauthorization is an administrative process and may be accomplished without a repeat face-to-face evaluation.

~~iv. If the recurring prior authorization request is modified or the level of service is decreased, the Alliance conducts another face-to-face assessment with the member and the process repeats as specified above.~~

~~v.~~iv. If a member no longer requires CBAS, CBAS providers are required to complete a CBAS Discharge Plan of Care. The CBAS Discharge Plan of Care includes:

a. The Member's name and ID number
b. The name(s) of the Member's Physician(s)
c. If applicable, the date of the Notice of Action denying authorization for CBAS was issued
d. If applicable, the date the CBAS benefit will be terminated
e. Specific information about the Member's current medical condition, treatments, and medications
f. Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge
g. Contact information for the Member's case manager
h. A space for the member or Member's representative to sign and date the Discharge Plan of Care.

~~vi.~~v. Communication and Coordination of Care

a. AAH will coordinate with the CBAS provider to ensure:
    - Timely exchange of the following coordination of care information:
    - Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and significant changes in the Member's condition.
    - Clear communication pathways between the appropriate CBAS Provider and staff and AAH staff (CBAS RN) responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team.
b. AAH will ensure that the CBAS Provider receives advance written notification and training prior to any substantive changes in AAH policies and procedures related to CBAS.

DEFINITIONS / ACRONYMS

" Out of Plan RN" refers to a professionally trained and licensed Alliance staff member in the

Utilization Management Department who assists assigned Members and their support systems in managing medical conditions and related psychosocial problems with the aim of improving health status and reducing the inappropriate use of medical services. The nurse provides care coordination and is an essential member of the Interdisciplinary Care Team.

"Community-Based Adult Services (CBAS)" shall mean an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutritional services, and transportation to eligible Medi- Cal beneficiaries who meet criteria as defined in the ~~California Bridge to Reform Waiver 11-W-00193/9, Special Terms and conditions, Paragraph 91.~~California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

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"CBAS Eligibility Determination Tool (CEDT)" is the screening tool developed by the California Department of Health Care Services that determines eligibility for CBAS services.

"Individualized Plan of Care (IPC)" is the document which delineates a CBAS participant's current or potential health-related problems, formulates an action plan to address areas of concern, and targets measurable goals and objectives. It is created after a multidisciplinary team assessment and includes problems, interventions, and goals for each core service as well as additional services provided by the CBAS provider.

"**Medical Necessity**" means those health care services and supplies which are provided in accordance with recognized professional medical practices and standards which are determined by a member's Primary Care Provider: (i) appropriate and necessary for the symptoms, diagnosis or treatment of Member's medical condition; and (ii) provided for the diagnosis and direct care and treatment of such health condition; and (iii) not furnished primarily for the convenience of Member, Member's family, or the treating provider or other provider; and (iv) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (v) consistent with Alameda Alliance policies..

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Long Term Care

RELATED POLICIES AND PROCEDURES

CBAS 002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 05/21/2020, 05/20/2021, 06/28/2022, 6/20/2023, 4/9/2024

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment A – CBAS Eligibility Determination Tool (CEDT)

REFERENCES

DHCS CBAS Contract, Exhibit A, Attachment 20.4

DHCS Contract, Exhibit E, Additional Provisions, Attachment 1, Definitions

Health and Safety Code 1367.01

California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

~~Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, amended 4/1/2012~~

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MONITORING

Monthly monitoring report that tracks volume of CBAS authorizations and processing turn-around-time.~~.~~

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	CBAS-001
Policy Name	Initial Member Assessment and Member Reassessment for Community-Based Adult Services (CBAS) Eligibility
Department Name	OP UM
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	Medi-Cal
Effective Date	10/01/2012
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

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PROCEDURE

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   b. If the RN is unable to contact the member and/or authorized representative by phone within eight (8) calendar days of the initial referral request, s/he makes final attempt in writing, giving the member until day 14 from initial referral to schedule face-to-face or Telephonic.

   c. If a member does not schedule within 14 days from initial referral, the Alliance will send a follow-up letter to member and requester informing them that if services are still needed, a new referral must be submitted to begin the process again.

iii. When an Alliance nurse successfully contacts the member and/or the authorized representative, the nurse confirms:

   a. Appropriateness of the referral, i.e., that the member meets the minimum qualifications.

3. An Alliance Registered Nurse with level of care experience arranges for a face-to-face interview with the member within 30 days from initial referral, employing the approved CBAS Eligibility Determination Tool (CEDT) (See Attachment A).

4. Plan staff, including RN Case Manager, approve or deny CBAS services based on information collected during the face-to-face assessment.

i. Denial of CBAS program:

   a. Member does not meet medical necessity criteria or member's need for services is not supported by CEDT.

   b. A denial of CBAS eligibility results in a Notice of Action (NOA,) which is sent to the member along with information on her/his right to file a Grievance and Appeal, Independent Medical Review and a State Fair Hearing. The CBAS provider also receives a copy of this letter. This letter is sent within five (5) working days of the face-to-face assessment.

   c. Grievance and Appeals

      - A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
      - A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

ii. Approval of CBAS program:

   a. Eligibility determination is communicated to the member and her/his

authorized representative within two (2) business days.

b. Authorization to conduct Individual Plan of Care (IPC) is communicated to the member's chosen CBAS provider within one (1) business day of the decision.

At this point, the CBAS provider is authorized to conduct a three (3) day multidisciplinary team assessment in order to produce an IPC, within 90 days.

5. CBAS center staff:

i. Performs three (3) day multidisciplinary team assessment.

ii. Based on the assessment, the CBAS center submits an Individualized Plan of Care (IPC) with level of service recommendation

iii. Submits a Prior Authorization request to the Alliance.

6. The Alliance:

i. Approves, modifies, or denies prior authorization request within five (5) business days in accordance with the standards set in the Health and Safety Code section 1367.01.

a. If the Alliance cannot make a decision within five (5) working days of receiving the authorization, the decision may be deferred, and the time limit may be extended no longer than 14 calendar days from the initial receipt of the authorization request. A deferral letter explaining the decision-making extension period is sent to the member and CBAS provider.

b. If a prior authorization request is denied or level of service is decreased (modified), a Notice of Action is sent to the member within 48 hours of decision, along with information on their rights to file a Grievance and Appeal, Independent Medical Review, and State Fair Hearing. The CBAS provider also receives a copy of this letter. The CBAS provider is notified within 1 Business Day.

c. Grievance and Appeals

- A member who receives a written NOA has the right to file an appeal and/or grievance under State and Federal law.
- A CBAS participant may file a grievance with the Alliance as a written or an oral complaint. The member or their authorized representative may file a grievance with the Alliance at any time they experience dissatisfaction with the services or quality of care provided to them. The Alliance provides information on the member's rights and how to file grievances/complaints in the Member Handbook, and it is published on the Member section of the Alliance website. If a member or authorized representative calls the Alliance to file a complaint or a grievance, Member Services will inform them of the procedure to file it.

ii. Approved services are authorized for a six-month period.

a. Member is notified within 2 Business Days of authorization.

b. Center is notified within 1 Business Dayof authorization.

7. Reassessment: In order for CBAS services to continue, the CBAS center sends a prior authorization request including an updated IPC with level of service recommendations to the Alliance prior to the expiration of the authorized six-month period.

i. A reassessment and redetermination of a member's eligibility for CBAS is completed at least every six (6) months after the initial assessment or whenever a change in circumstances occurs that may require a change in the member's CBAS benefit.

ii. If a member is already receiving CBAS services and requests that services remain at the same level or be increased due to a change in level of need, the Alliance conducts the reassessment using only the member's IPC and any supporting documentation supplied by the CBAS Provider.

iii. Reauthorization is an administrative process and may be accomplished without a repeat face-to-face evaluation.

iv. If a member no longer requires CBAS, CBAS providers are required to complete a CBAS Discharge Plan of Care. The CBAS Discharge Plan of Care includes:

   a. The Member's name and ID number
   b. The name(s) of the Member's Physician(s)
   c. If applicable, the date of the Notice of Action denying authorization for CBAS was issued
   d. If applicable, the date the CBAS benefit will be terminated
   e. Specific information about the Member's current medical condition, treatments, and medications
   f. Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge
   g. Contact information for the Member's case manager
   h. A space for the member or Member's representative to sign and date the Discharge Plan of Care.

v. Communication and Coordination of Care

   a. AAH will coordinate with the CBAS provider to ensure:
      - Timely exchange of the following coordination of care information:
      - Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and significant changes in the Member's condition.
      - Clear communication pathways between the appropriate CBAS Provider and staff and AAH staff (CBAS RN) responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team.
   b. AAH will ensure that the CBAS Provider receives advance written notification and training prior to any substantive changes in AAH policies and procedures related to CBAS.

DEFINITIONS / ACRONYMS

" Out of Plan RN" refers to a professionally trained and licensed Alliance staff member in the Utilization Management Department who assists assigned Members and their support systems in managing medical conditions and related psychosocial problems with the aim of improving health status and reducing the inappropriate use of medical services. The nurse provides care

coordination and is an essential member of the Interdisciplinary Care Team.

"Community-Based Adult Services (CBAS)" shall mean an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutritional services, and transportation to eligible Medi- Cal beneficiaries who meet criteria as defined in the California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, Special Terms and Conditions, Project No: 11-W-00193/9

"CBAS Eligibility Determination Tool (CEDT)" is the screening tool developed by the California Department of Health Care Services that determines eligibility for CBAS services.

"Individualized Plan of Care (IPC)" is the document which delineates a CBAS participant's current or potential health-related problems, formulates an action plan to address areas of concern, and targets measurable goals and objectives. It is created after a multidisciplinary team assessment and includes problems, interventions, and goals for each core service as well as additional services provided by the CBAS provider.

"**Medical Necessity**" means those health care services and supplies which are provided in accordance with recognized professional medical practices and standards which are determined by a member's Primary Care Provider: (i) appropriate and necessary for the symptoms, diagnosis or treatment of Member's medical condition; and (ii) provided for the diagnosis and direct care and treatment of such health condition; and (iii) not furnished primarily for the convenience of Member, Member's family, or the treating provider or other provider; and (iv) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (v) consistent with Alameda Alliance policies..

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Long Term Care

RELATED POLICIES AND PROCEDURES

CBAS 002 Expedited Initial Member Assessment for Community-Based Adult Services (CBAS) Eligibility

REVISION HISTORY

06/16/2016, 09/06/2018, 04/15/2019, 05/21/2020, 05/20/2021, 06/28/2022, 6/20/2023, 4/9/2024

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment A – CBAS Eligibility Determination Tool (CEDT)

REFERENCES

DHCS CBAS Contract, Exhibit A, Attachment 20.4

MONITORING

Monthly monitoring report that tracks volume of CBAS authorizations and processing turn- around-time.