ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	RX-013
Policy Name	Medical Benefit Physician/Facility-Administered Drugs (PAD) Prior Authorization Review Process
Department Name	Pharmacy Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Pharmacy Services
Line(s) of Business	MCAL, IHSS
Effective Date	7/17/2023
Subcommittee Name	Pharmacy and Therapeutics Committee
Subcommittee Approval Date	6/11/2024
Administrative Oversight Committee Approval Date	8/21/2024

POLICY STATEMENT

The Alameda Alliance for Health (the "Alliance") has an established process for reviewing and processing medical necessity-based physician/facility-administered drugs (PAD) authorization requests for pharmaceutical services that are on the formulary. The Alliance is committed to ensuring that all eligible Alliance members have timely and efficient access to covered pharmaceutical services that require authorization. The Alliance's pharmaceutical authorization process complies with the standards set by the California Health & Safety Code, Sections 1367.01, 1373.96; the California Code of Regulations (CCR) Title 28, Sections 1363.5, 1367.01, . The Alliance covers medications for treating gender dysphoria or alleviating mental health or substance use. The Alliance ensures parity in coverage of pharmaceuticals used to treat medical/surgical, mental health, and substance abuse disorders.

PROCEDURE

I. Prior Authorization Process Guidelines

A. Prior authorization review and approval hierarchal criteria are utilized and required as outlined in UM-001 (or with PAD Medication Review Guidelines) for the appropriate pharmacy authorizations.

B. The Alliance utilizes evidence-based prior authorization criteria approved by the P&T Committee. Prior authorization criteria are developed and reviewed annually and are based established by organizations such as Medi-Cal guidelines (if for Medi-Cal line of business), Milliman Care Guidelines, Food and Drug Administration (FDA), National Comprehensive Cancer Network (NCCN), UpToDate, and National Institutes of Health (NIH). The Alliance

covers pharmaceuticals in accordance with 42 CFR section 438.900 et seq, to ensure parity in medical/surgical, mental health, and substance abuse benefits and treatment.

II. Prior Authorization Procedures

A. All providers are required to submit prior authorization for Healthcare Common Procedure Coding System (HCPCS) / National Drug Code (NDC) codes that are listed and in alignment with P&T committee approved PA criteria as appropriate.

B. Required information provided on all requests should include:

a) Member demographic information
b) Practitioner demographic information
c) Requested service/procedure to include specific Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code(s)
d) Member diagnosis (Specific International Classification of Disease (ICD) Code/Description)
e) Clinical indications necessitating service
f) Pertinent medical history, treatment, or clinical data
g) Location of service to be provided
h) Requested/anticipated duration of therapy
i) Proposed date(s) of services

C. Prior authorization requests must be submitted electronically or by fax to the Alliance UM Department.

a) Pharmacy department will manage the end-to-end process when providers send a PAD PA for the Alliance members. This entails some of the following duties below:
    i. Verify eligibility, coverage, and network
    ii. Check if there are benefit restrictions
    iii. Generate letter of notifications for approval, partial approval, and denial

A. Retro Requests: The Alliance does not accept post-service or retrospective authorization requests for nonemergent or non-urgent services that would require prior authorization more than 90 days past the date of service.

The exception criteria under which a post service / retrospective request greater than 90 days after the date of service may be considered are:

1. Member eligibility issues, i.e., unable to validate eligibility at time of service, incorrect eligibility information at time of service.
2. In-patient services where the facility is unable to confirm enrollment with the Alliance.

B. Pre-Service/Post-Service Review for Pharmacy Technician (PT)
    A. Upon receipt of the authorization request, the PT will review the request for:
        (1) Member eligibility
        (2) Completeness of the request
            (a) Presence of medical codes,
            (b) Presence of medical records
    B. Once the authorization request review is complete, the PT enters the authorization request into the clinical information system and routes it to the appropriate UM PT processing queue.
    C. Upon selecting authorization request from the queue, the assigned PT reviews the pre-service/post-service authorization request that includes:

(1) The UM PT reviewer performs a review of the pre-service/post-service/ associated with PAD authorization request and clinical information presented using the appropriate UM criteria, according to UM-001 Utilization Management Policy or UM Program.

(a) The PT Reviewer documents the decision-making process in the clinical information system.

(b) The PT Reviewer workflow includes:

(i) For authorization requests meeting criteria under the scope of the PT, the PT Reviewer approves the request and generates the Member and Provider approval notification.

(ii) For authorization requests not consistent with the request (i.e., conflicting CPT Codes to diagnosis, conflicting HCPCs to documentation, etc.), or otherwise are outside of PT scope, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the PT Reviewer forwards the request to the Pharmacist Reviewer.

C. Pre-Service/Post-Service Review Pharmacist Reviewer (PR)

A. Pharmacist Reviewer performs a medical necessity review of the authorization request and clinical information presented using the appropriate UM criteria, according to UM-001 Utilization Management Policy or UM Program.

(1) The PR utilizes evidence-based criteria and hierarchical criteria process for approving, modifying, deferring, requested services (as applicable).

(a) The hierarchal criteria process:

(i) Regulatory and contractual requirements

(ii) Evidence based guidelines

(iii) Alliance specific guidelines

(iv) National medical association consensus

(v) Medical necessity/medical judgement

(2) The PR Reviewer documents the clinical decision-making process in the clinical information. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.

III. The Alliance's Pharmacy Department processes pharmacy authorization requests in accordance with the procedures described in UM Policy # 001 – Utilization Management and UM Policy #057 (as it may relate to pharmacy services).

a. Outreach calls (up to 3 attempts) may be made to the requesting provider to request reasonably necessary clinical information when needed to make a PA decision or enter missing required clinical information for medication requests. For each outreach attempt, the reviewer is to document the following:

i. Name and title of person spoken to

ii. Phone number called (if different from one already noted in the PA system)

iii. What specific information was requested

IV. Continuity of Care for Covered Services for Newly Enrolled Medi-Cal and GroupCare Beneficiaries

A. PAD CoC requests are managed using the same mechanisms and processes as UM Policy #036 Continuity of Care for Terminated and Non-Participating Providers, UM Policy #058, Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving A Medical Exemption, and UM Policy#059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into MediCal Managed Care.

V. Continuation of Therapy

A. The Alliance shall allow continuation of therapy for members using medically necessary drugs when it can be shown through clinic notes or medication fill history that the member has been taking the medication prior to enrollment.

B. For transitioning members until the Beneficiary can be seen by a Plan provider to establish a care plan, as required by Welfare & Institutions (W&I) Code, Section 14185(b), the Alliance will allow for continuation of medically necessary medications if provided clinic notes showing all of the following:

1. Patient name
2. Medication name, dose, and route of administration
3. Quantity distributed
4. Date medication was started and date last given/filled

VI. Annual Review of PAD Prior Authorization and UM Criteria

a. All PAD utilization management criteria undergo annual evaluation for appropriateness and effectiveness. Criteria are updated when necessary. The P&T committee reviews the pharmacy UM program, including delegated elements. The review encompasses scope, policies and procedures, and criteria as appropriate.

VII. Monitoring of the PA process

a. Inter-rater Reliability- the Alliance evaluates the consistency of decision making for those health care professionals involved in applying PAD Criteria.

VIII. Pharmacy Department will communicate with Utilization Management (UM), Communications & Outreach, Medical Directors, Provider Services (PR), Member Services (MSR), Claims and Benefit Configuration Departments to implement prior authorization restriction requirements in Heath Suite and outreach to providers and members.

IX. Pharmacy Services will comply with appropriate UM policies as they relate to pharmacy supported authorizations, NOA letters and regulatory requirements (see related policies section for reference).

DEFINITIONS / ACRONYMS

- PAD: Physician/Facility-Administered Drugs
- NCQA: National Committee on Quality Assurance
- UM: Utilization Management

AFFECTED DEPARTMENTS/PARTIES

Pharmacy Services
Utilization Management
Claims

Benefit Configuration
Member Services
Provider Relations
Communications and Outreach

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management
UM-036 Continuity of Care for Terminated and Non-Participating Providers
UM-051 Timeliness of UM Decision Making and Notification
UM-051 Attachment A UM Timeliness Standards for Medi-Cal and Group Care
UM-054 Notice of Action
UM-057 Authorization Service Request
UM-058 Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving A Medical Exemption
UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into MediCal Managed Care

REVISION HISTORY

6/20/2023, 12/19/2023, **8/21/2024**

Red = Substantive Upates

REFERENCES

- NCQA UM 12, Element A**,** B, D
- Alliance Provider Manual
- Health & Safety Code, Sections 1363.5, 1367.01, 1367.21, 1367.215, 1373.96
- Senate Bill 855 – Mental Health as a Medical Necessity
- DHCS All Plan Letter 22-012 Governor's Executive Order N-01-19, regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
- DMHC APL 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx
- DHCS All Plan Letter 22-032 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal FFS, and for Medi-Cal Members who Transition into a New Medi-Cal Managed Care Health Plan on or after January 1, 2023
- DHCS APL 23-004 Skilled Nursing Facilities -- Long Term Care Benefit Standardization And Transition Of Members To Managed Care
- DHCS APL 23-027, Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- DHCS APL 23-023 – Intermediate Care Facilities for Individuals with Developments Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
- DHCS Contract #23-30212, Exhibit A – Scope of Work
- 2024 Medi-Cal Managed Care Plan Transition Policy Guide

MONITORING

This policy will be reviewed annually to ensure effectiveness.

APPENDIX

Table 1: Medical Benefit Determination Turnaround Timetable of Different Regulatory Bodies

Type of Request	NCQA	DHCS	DMHC	**Alliance**
Prospective, Urgent	72 hours	72 hours	72 hours	**72 hours**

Prospective, Non-Urgent	Medi-Cal: 14 calendar days Group Care: 15 calendar days	5 business days	5 business days	**5 business days**
Post-service	30 calendar days	30 calendar days	30 calendar days	**30 calendar days**

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POLICY AND PROCEDURE

Policy Number	UM-052
Policy Name	Discharge Planning to Lower Level of Care, (Including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days)
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	05/25/2017
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/16/2024
Compliance Committee Approval Date	3/19/2024

POLICY STATEMENT

1. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.
2. The attending physician is responsible for evaluating the post - acute admission needs of the member and determine the type of recovery prior to discharge.
3. Administrative bed days will be reviewed under the inpatient authorization process. Administrative bed days will be reviewed for authorization by Alameda Alliance for Health (AAH) while the member is in an acute care inpatient facility which provides a higher level of care than what is needed currently by the member. These days will be authorized when the appropriate guidelines below are followed while the patient remains in an acute care inpatient facility while patient is waiting for a placement in recovery facilities.

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

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

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

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

PROCEDURE

A. Discharge Planning to a Lower Level of Care Facility

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

a) At the time of admission, the hospital discharge planner, case manager or social worker documents the member's discharge planning and TCS needs and associated barriers to discharge in a note.

b) Transitional Care Services (TCS) includes:

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

ii. Discharge Risk Assessment

iii. Discharge Planning document

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

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

3. The Alliance UM Nurse/Reviewer will review member's needs using the Medi-Cal guidelines and the MCG guidelines for recovery facility placement

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

5. When significant barriers to placement exist, the Alliance UM Nurse/Reviewer will assist the facility in locating accepting facilities capable of managing the members' care needs. Discharge barriers could include

a) Bariatric Needs

b) Bedside Dialysis Needs

c) Isolation

d) Social Determinants of Health (Including Homelessness)

e) Long-Term Care (Custodial) Placements

f) Aggressive or Wandering Behaviors

g) History of Member Elopement/ AMA

6. The AAH UM staff will assist in contacting potential accepting facilities

a) The AAH UM staff will initiate the Letter of Agreement (LOA) process for Out of Network (OON) facilities that would accept the member for care. The procedure for discharge to the out of network facility will be coordinated with the OON facility and agreed upon before the discharge to ensure that the Member's needs are met during and after the transition. The option to create an ongoing contract with the OON facility will be offered.

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

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

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

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

1. AAH will authorize administrative bed days in facilities that have Administrative Day level of care in their contract with AAH, if the hospital follows the following guidelines.

2. Day 1:

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

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

c) The administrative day will be authorized.

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

3. Day 2:

a) Hospital staff will attempt to find appropriate placement for the member by calling at least ten (10) contracted lower level of care facilities.

b) Hospital staff will send the list of facilities contacted to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

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

d) The administrative day will be authorized

e) The Hospital should plan to initiate the outreach outlined in Day 3 below

4. Day 3:

a) Hospital staff will call the Alliance UM Nurse/Reviewer for assistance if no placement has been made.

b) Hospital staff will continue to call at least five (5) facilities, send the list of facilities contacted to the Alliance UM Nurse/Reviewer assigned to the hospital where the member is admitted.

c) Hospital staff will record the list of facilities contacted and send it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

d) The Alliance UM staff will send a fax blast to both contracted facilities and non-contracted facilities.

e) The Alliance UM Nurse/Reviewer will also assist by contacting contracted and non-contracted facilities in order to facilitate placement

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

g) The administrative day will be authorized

h) The Hospital should continue to initiate the outreach outlined in Day 4, and Day 5 and ongoing.

5. Day 4:

a) Hospital staff will call at least five (5) facilities and send the list of facilities contacted it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

b) The Alliance UM Nurse/Reviewer may also assist by contacting contracted and non-contracted facilities in order to facilitate placement

6. Day 5: and ongoing days until discharge

a) Hospital staff will call at least five (5) facilities and send the list of facilities contacted it to the Alliance UM Nurse/Reviewer assigned to the hospital where member is admitted. The deadline will be 3:00 pm.

b) The Alliance UM Nurse/Reviewer may also assist by contacting contracted and non-contracted facilities in order to facilitate placement

c)The Alliance Nurse/Reviewer will escalate the case to the Managers

d) For complex placements, the Alliance Medical Director may be consulted for medical related issues.

C. Delegation Oversight

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

DEFINITIONS

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

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

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 Utilization Management Program

UM-003 Concurrent Review and Discharge Planning Process

UM-051 Timeliness of UM Decision Making

UM-054 Notice of Action

UM-057 Authorization Request

UM-060 Delegation Management and Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

Attachment #1 - Request to Discharge Members to Lower Level of Care Proof of Placement Log

REVISION HISTORY

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

REFERENCES

DHCS Contract, Exhibit A, Attachment 8
CDPH AFL 10-21

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	UM-001
Policy Name	Utilization Management Program
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director of Utilization Management
Line(s) of Business	MCAL, IHSS
Effective Date	11/02/2004
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	8/21/2024

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.

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, **8/16/2024**

Red = Substantive Updates

REFERENCES

1. DHCS Contract, Exhibit A, Attachments 5, 9, 13
2. Title 22, Section 51159
3. 28 CCR, §1300.51 (d)(I-6)
4. Health & Safety Code, Section 1367.01
5. 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-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.

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POLICY AND PROCEDURE

Policy Number	UM-003
Policy Name	Concurrent Review and Discharge Planning Process
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Senior Director, Health Care Services
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

This policy addresses the provision of inpatient services provided in an acute and long-term care acute inpatient settings: medical/surgical or behavioral. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.

Admission Review: Admissions to the acute hospital / long-term care acute hospital (LTACH)/ inpatient behavioral, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Sub-acute facility (peds and adults), SNF, acute Rehabilitation facility, etc.) for elective or non-elective diagnostic or therapeutic reasons must meet the guidelines for admission, utilizing approved written criteria, whether or not the admission was prior approved.

Continuous Stay Review: Subsequent review for ongoing medical necessity. Continued stay, (timeframe dependent upon the diagnosis and the progress of the patient) review will be performed using written criteria for medical necessity/continuous care and must be met to be approved.

PROCEDURE

A. Admission Review

1. The contracted Hospitals/ facilities will fax a copy of the admission face sheet for any new

admissions to the health plan within 24 hours of the admission.

   a. Elective admissions will have a tracking number and pre-certification referral on file.

   b. Emergent admissions will require new case creation.

2. All facilities, contracted and non-contracted, must notify the Alliance within 24 hours of a change in the level of care or discharge from facility.

   a. Upon request, facilities must submit clinical information to the Alliance UM Department by the end of the next business day from the time of the request.

   b. Notifications and clinical notes received outside of the above timeframes may result in a delay/ deferral, or denial of the authorization for service and payment.

3. The timeliness of the admission review is based on the member's line of business:

   a. Medi-Cal: reviewed within 24 hours of receipt of the request.

   b. Group Care: reviewed within 24 hours of admission, even during non-business operating days. This ensures compliance with 45 CFR § 146.136 for the Mental Health Parity and Addiction Equity Act (MHPAEA) that requires the same standards applied for medical/surgical and mental health and/or substance abuse disorder benefits. This includes the standards for the UM authorization process and criteria applied for medical necessity review.

4. Eligibility and member's delegate assignment will be verified.

5. Authorization number will be assigned by the data system.

6. The review process may include, but not be limited to, the following:

   a. Chart review;

   b. Data collection;

   c. Application of evidenced based criteria to determine the medical necessity of admission

   d. Review of care plans; and/or

   e. Transition of care services (TCS), social determinants of health (SDOH), and discharge planning

7. Complex and/or catastrophic cases will be discussed with the Medical Director or Director of Utilization Management.

8. The Medical Director may consult with the admitting physician on questions of medical necessity.

   a. If the Medical Director/ designee, following that consultation, determines the hospitalization is inappropriate, an alternative plan will be discussed with the admitting physician and a patient discharge will be requested.

   b. Inpatient care will be continued until the treating physician is notified and agrees on an appropriate care plan.

   c. Notifications will be made according to established regulatory requirements if the admission does not meet medical necessity criteria. (See most recent versions of DHCS Notice of Action Templates or Commercial – IHSS UM Determination Templates)

   d. Only a Medical Director/ designee or doctoral Behavioral Health Practitioner may

make a decision to deny services when medical necessity criteria are not met.

B. Medical Concurrent Review

1. Concurrent review is performed applying written criteria to determine medical necessity on a daily basis or on the cadence indicated in the criteria guidelines or based on the member's clinical condition:
   a. Two (2) to five (5) days a week, as appropriate for medical care review.
   b. Not more than two (2) days per week for mental health and substance use admissions.
   c. The patient is followed through the continuum/ levels of care, until they have returned to the optimum level of functioning.
   d. Inpatient stay days for recipients who no longer require acute hospital care and are awaiting placement in a nursing home or other subacute or post-acute care or next level of care, Utilization Management staff will continue to perform continued stay reviews. The minimum review frequency is every 1 week or when the member's condition changes, until the Member is safely transitioned to the next level of care. Standard Concurrent Review processes will be utilized, including physician review as needed. Notice of Action letters are sent to members and requesting providers for each concurrent review resulting in a denial of services. See UM Policy UM-052.
2. Concurrent review information is obtained either via telephonic review, review of Electronic Health Record , by the portal or by fax, by a UM Clinical Reviewer.
   a. Select Medical Groups/ IPAs are delegated to perform concurrent review of assigned members applying written criteria, at the appropriate clinical cadence while hospitalized.
   b. The health plan and Medical Group/ IPA UM Department coordinate with each other, as appropriate.
3. Documentation is entered in the plan's database:
   a. Member progress is documented in a clinical note in the plan's database.
   b. The review cycle is continued at the appropriate clinical cadence until discharge.
   c. Documentation includes the date, time, and condition upon patients' discharge.
4. Following review, if the Medical Director determines the patient does not meet the medical necessity criteria for the current level of care and could be safely discharged or transferred to a lower level of care:
   a. The Reviewer will assess if adequate discharge efforts were made by the current facility, and if there is evidence of an unsafe discharge plan in place for the member (see UM-052).
   b. Only a Medical Director or designee/doctoral Behavioral Health Practitioner may make a decision to deny services.
   c. Qualified Medical Directors or designees review all denials of continued acute and long-term acute care hospitals (LTACH), Subacute, ICF-DD, Skilled Nursing Facility, and acute Rehabilitation facilities, services throughout the members' hospital stays.

C. Notice of Action Letters

1. For admissions that do not meet ongoing medical necessity for initial admission or continued stay, Medi-Cal members and providers are sent a Notice of Action (NOA) letter, for the initial denial and at every subsequent review. See UM-054 Notice of Action and UM-057 Authorization Request, for details on decision notification content and appeal rights.
    a. All other lines of business – send standard denial NOA letter if coverage is being discontinued.
2. The UM Staff responsible for letters will follow the Standard Review procedures which includes the requirement that members and providers are given a NOA letter with accurate information about the denied date(s) and the requesting providers.
3. UM Staff will generate NOAs in the UM Information System, TruCare, which is configured to display the correct dates and providers in the automated portion of the NOA letters.
4. Prior to final issuing of NOAs, UM staff will verify the dates, service request/ stay level on the NOA match the dates of the final determination.
    a. NOAs found with discrepancies are immediately brought to the attention of UM Management team for immediate intervention.

D. Discharge Planning for All Lines of Business

1. Discharge planning and transitions of care services (TCS) begins at the time of admission for unscheduled patient stays and prior to admission for elective inpatient stays and continues throughout the patient's stay. The patient's progress is evaluated in order to plan for a timely discharge to the appropriate level of care with any scheduled home care or equipment as applicable.
    a. The discharge plan will be coordinated with the attending physician, the member and/or family, the hospital staff, the identified TCS care manager and any appropriate home health agencies/ vendors (i.e., home health, DME vendors, infusion services, etc.) or transportation needs.
    b. The need for patient education will be assessed as part of the Discharge Planning process.
    c. Evaluation of the discharge plan is included in the concurrent review sessions between the UM Clinical Reviewer, the Medical Director and facility's discharge planning staff.
        1). The member will be evaluated for potential alternative care needs.
        2). The attending physician will be responsible for keeping the member and family informed of progress toward discharge or transition to an alternative level of care.
        3). Notification of transition to an alternative level of care:
            i). Medi-Cal members and providers are sent a Notice of Action (NOA) letter.
            ii). All other lines of business – send standard denial letter if coverage is being changed/discontinued.
    d. Based on the discharge plan, the UM Clinical Reviewer will verify benefits for services and provide contracted vendor information and issue an authorization

number to the Hospital Case Manager, as appropriate.

e. Non-clinical staff may administratively enter limited visit authorizations for Home Health follow-up when a Home Health order is in place and an accepting provider has been identified.

f. The UM Clinical Reviewer will coordinate the notification of the appropriate vendor regarding the discharge plan, date of discharge, and provide the authorization number.

g. The UM Clinical Reviewer will apprise the appropriate TCS Care Manager, of the discharge for the purpose of scheduling follow-up care, as needed.

h. For discharge to a lower level of care facility:

1). The discharge plan will be coordinated with the attending physician, the member and/or family member or designated decision maker, and the hospital interdisciplinary staff. Evaluation of the discharge plan is included in the concurrent review process with the AAH UM Nurse/Reviewer, the facility discharge planning staff, the identified TCS Care Manager and the AAH Medical Director as indicated.

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

i). When significant barriers to placement exist, the Alliance UM Nurse/Reviewer will assist the facility in locating accepting facilities capable of managing the members' care needs.

- The AAH UM staff will assist in contacting potential accepting facilities.
- The AAH UM staff will initiate the Letter of Agreement (LOA) process for Out of Network (OON) facilities that would accept the member for care. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member. The procedure for discharge to the out of network facility will be coordinated with the OON facility and agreed upon before the discharge to ensure that the Member's needs are met during and after the transition. The option to create an ongoing contract with the OON facility will be offered.
- The case will be discussed at Extended Length of Stay Rounds to identify placement options.
- If LOS is prolonged, the AAH UM staff will escalate the case to AAH clinical and operational leadership to develop strategies to locate appropriate placement. See UM-052
    - Strategies to locate placement may include working administratively with facilities to develop capacity to manage the member's needs, contacting DHCS to assist in problem resolution, and/or identify contractual opportunities regarding placement.

E. Discharge Planning and Care Coordination, including for SPD Members

1. Discharge planning covers the period from admission to a hospital or institution and continues into the post-discharge period and ensures:
    a. Necessary care, services and supports are in place in the community after discharge.
    b. Outpatient appointments and/or follow-up visits with the member and/or caregiver are scheduled.
    c. Placement in lower level of care facilities is a coordinated transition of care.
    d. All discharge planning applies to in-network providers/ facilities or out of network (OON) providers/ facilities if needed to meet the needs of the members.
    e. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member.
2. Discharge planning is:
    a. Conducted through collaboration between the hospital/institution discharge planning staff and the Alliance UM Clinical Reviewer and the identified TCS Care Manager.
    b. Based on the DHCS PHM Policy Guide the MCP must have oversight of the Hospital's discharge planning process to ensure they assess, at minimum, a member's risk of:
        1). Re-institutionalization,
        2). Re-hospitalization,
        3). Destabilization of a mental health condition,
        4). And/or SUD relapse.

    c. Documented in both the hospital's patient medical record and/or the Alliance's member database and includes the following elements:
        1). Pre-admission status, including living arrangements, physical and mental function, social support, DME, and other services received.
        2). Pre-discharge factors including an understanding of the medical condition by the member/representative as applicable, physical and mental function, financial resources, and other social determinants of health, and social supports.
        3). Services needed after discharge to include:
            i). Type of placement preferred and agreed to by the member/ family representative or designated decision maker.
            ii). Specific agency/ home recommended by the hospital and agreed to by the member/representative or designated decision maker.
            iii). Eligibility for ongoing care management services such as ECM, Complex CM, or other community case management services.
            iv). Recommended pre-discharge counseling.

        4). Summary of the nature and outcome of:
            i). Member/ representative or designated decision maker, involvement in

the discharge planning process

ii). Anticipated problems in implementing post-dischargeplans

iii). Further action contemplated by the hospital/institution.

F. Behavioral Health Concurrent Review Process

1. Concurrent review is conducted for mental health and substance use disorder inpatient admissions. For behavioral health care, concurrent reviews for inpatients occur no more than every three (3) days. For residential treatment, reviews occur monthly.

2. Medical necessity determinations for Group Care members are based on non-profit professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), World Professional Association for Transgender Health (WPATH), Counsel of Autism Services Providers, American Psychiatric Association, and the American Psychological Association.

3. Concurrent review processes for behavioral health follow the same information gathering, documentation, medical review and notice of action (NOA) processes as described in this policy for medical services.

4. G. **Inpatient Behavioral Health Discharge Planning Coordination**

a. The discharge plan is reviewed for appropriateness, based on the individual's needs, and may include the following:
b. The discharge plan is realistic, comprehensive, timely and concrete;
c. The plan takes into consideration the AAH BH Clinician's recommendations and member's preferences, as recorded in previous treatment review notes;
d. Transition from one level of care or program to another is coordinated, and involves coordination with ACBHCS for Medi-Cal members with SMI/SUD;
e. AAH incorporates actions to assure continuity of existing therapeutic relationships, as appropriate;
f. The provider assists the member, parent, or guardian to understand the status of the discharge plan and has a signed copy;
g. Transportation and other needs are addressed as applicable;
h. The discharge plan is communicated to the aftercare provider(s) as applicable and with the member's permission;
i. Psychopharmacological needs are addressed;
j. Medical condition(s) follow-up needs are addressed.
k. Collaboration with medical practitioner has occurred, as necessary;
l. The member has timely access to the recommended aftercare services including date of first appointment, with whom, where, and other treatment and community resources to be utilized;
m. Barriers to aftercare planning are addressed and need for outreach or treatment reminders are indicated;
n. Support systems are outlined;
o. Community services and/or self-help groups are recommended;
p. Linkages to EAP services are established as appropriate;

q. Family/Work/Community preparation has occurred which supports reintegration as appropriate.
r. Review of all ongoing and new in-network continuing care services (both covered and non-covered) to assist the provider/facility in identifying appropriate resources for discharge planning.

G. Transitional Care Services

1. The UM Clinical Reviewer will make referrals to Case/Disease Management and/or the Behavioral Health staff as appropriate, to provide Transitional Care Services at the beginning of the stay to ensure that a safe and appropriate transition plan is enacted for the member.
   a. Transitional Care Services (TCS) includes:
      - Identification of a Care Manager for TCS and communication of the Care Manager assignment to the member and facility to facilitate the participation of the Care Manager with the discharge planning and follow up.
      - Discharge Risk Assessment
        - Based on the DHCS PHM Policy Guide the MCP must have oversight of the Hospital's discharge planning process to ensure they assess, at minimum, a member's risk of:
          - re-institutionalization,
          - re-hospitalization,
          - destabilization of a mental health condition,
          - and/or SUD relapse.
      - Discharge Planning document.
      - A full description of the Alliance TCS program is found in CM-034 Transition of Care policy.
2. The member's needs are identified based on the following:
   a. Social environment
   b. Support structure through family and friends
   c. Availability and accessibility of needed services
   d. General Safety
   e. Complete care of the member on a continuum, including mental health and substance abuse services.

H. <u>Post- Acute care Admission to Hospice</u>:

a. Hospice services will be provided to any member who receives a physician's certification that the member has a terminal illness and who elects hospice services.

b. Covered hospice services will be made available in a timely manner, preferably within 24 hours of the request.

c. Only general inpatient hospice services are subject to prior authorization (PA). PA is not a Medi-Cal requirement for routine home care, continuous home care, or hospice respite care.

d. The following settings are considered appropriate for post-acute care admission into

Hospice:

i. The member's home;
ii. A distinct part of a hospital psychiatric or rehabilitation unit;
iii. A home-based community setting; or
iv. A transition into the home.

I. Admission to Out of Network (OON) or Out of Area Facilities

1. Emergency admission to an OON or Out of Area facility will be followed by the UM or Behavioral Health (BH) Department. The UM/BH Clinical Reviewer will follow the member, utilizing the above guidelines, until the member is able to be safely transferred back into the appropriate network. The LOA process will be enacted for the Out of Network facility as needed or invited to contract with AAH.
2. The UM/BH Department will collaborate on a plan of care for a member who is being prior-authorized for out-of-area/network care. This includes referral to the TCS program to ensure that the safe and appropriate discharge plan and follow up care is enacted. The OON facility and AAH will mutually agree to the policies and procedures for discharge planning and transitional care services for the member.
3. The Member Services department will be notified if it appears that the member has moved permanently out of the area.

J. Coordination with Behavioral Health

1. Admissions related to behavioral health conditions are managed by the behavioral health staff and in compliance with the regulatory requirements and most recent DHCS All Plan Letter related to Medi-Cal Managed Care Health Plan Responsibilities for Mental Health Services.
2. Behavioral health admissions are co-managed when necessary to ensure the collaboration of medical and behavioral health services. AAH will facilitate access to necessary medical information and services for transition or discharge planning.
3. Members identified with need for medical case management services will be referred as defined in CM policy.

L. Delegation Oversight

1. The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS AND ACRONYMS

Concurrent request – A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Discharge Planning – The activities that facilitate a patient's movement from one health care setting to another, or to home. It is a multidisciplinary process involving physicians, nurses,

social workers, and potentially other health professionals; its goal is to enhance continuity of care. It begins on admission.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

BH-001 Behavioral Health Services
CM-001 Complex Case Management Identification, Screening Assessment and Triage
CMP-019 Delegation Oversight
UM-001 Utilization Management Program UM-051 Timeliness of UM Decision Making
UM-052 Discharge Planning to Lower Level of Care, Including Granting Administrative Days Pending Placement for Facilities contracted for Administrative Days
UM-054 Notice of Action
UM-057 Authorization Request UM-060 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

11/21/2006, 1/1/2008, 1/16/2009, 4/13/2011, 9/7/2012, 7/13/2013, 3/14/2014, 12/9/2016, 12/15/2016, 4/12/2018, 04/15/2019, 09/19/2019, 1/21/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 9/19/2023, 7/17/2024, 12/18//2024

REFERENCES

1. 45 CFR §146.136 Mental Health Parity and Addiction Equity Act
2. DHCS Contract, Exhibit A, Attachment 5, Provisions 2 and 3
3. DHCS PHM Policy Guide May 2024
4. DHCS PHM FAQ June 2024
5. Title 42, CFR, Sections 422.118 and 422.620

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	UM-005
Policy Name	Second Opinions
Department Name	Health CareServices
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	02/01/2000
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	7/17/2024

POLICY STATEMENT

A. PCP (Primary Care Physician)/BH (Behavioral Health) Providers, Specialists, and Members (if the practitioner refuses), have the right to request a second opinion from a qualified health professional, at no cost to the Member from the Alliance, (Per 42 CFR section 438.206,) regarding proposed medical, surgical or behavioral health treatments from an appropriately qualified participating healthcare professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to theparticular illness, disease condition, or conditions associated with the request for a second opinion.

B. Second opinions from contracted providers do not require authorization and are arranged through the Member's assigned PCP or BH Provider.

C. The Alliance provides for a second opinion from a qualified health care professional in network or arranges for the enrollee to obtain one out of network, at no cost to the enrollee.

D. A prior authorization from the Alliance is required to receive a second opinion from an out-of-network provider. The time frames for processing second opinions follow the standard authorization time frames.

E. The second opinion authorization or a denial shall be provided in an expeditious manner appropriate to the nature of the member's condition, not to exceed 72 hours after the Alliance's receipt of the request.

PROCEDURE

A. Members should request a second opinion through their PCP, specialist, or BH Provider. If the PCP, specialist, or BH Provider refuses to submit a request for a second opinion, the Member can submit a grievance or a request for assistance through the Alliance Member Services.

B. Second opinions rendered by a contracted Alliance provider does not require prior authorization; the member's PCP, specialist, or BH Provider can coordinate the referral directly with the provider rendering the second opinion. Members can call the Alliance Member Services department to obtain assistance with this coordination.

C. Second opinions rendered by a non-contracted Alliance provider do require prior authorization. The PCP, specialist, or BH Provider submits the authorization request for a second opinion to the Alliance including documentation regarding the Member's condition and proposed treatment.

D. If the referral for a second opinion is approved, the Alliance makes arrangements for the Member to see a physician/BH Provider in the appropriate specialty.

E. If the referral for an out of network second opinion is denied or modified, the Alliance provides written notification to the Member including rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision.

F. The Alliance must consider the ability of the Member to travel to the second opinion practitioner's office, and if necessary, arrange transportation for the Member.

G. If there is no physician within the Alliance network that meets the qualifications for a second opinion, the Alliance must authorize a second opinion by a qualified physician or BH Provider outside the Alliance network.

H. Members disagreeing with an Alliance or Delegated Medical Group (DMG) denial of a second opinion may appeal through the Alliance appeal process.

I. In situations where the Member believes that the need for a second opinion is urgent, they can request facilitation by the Alliance by contacting the Alliance Member Services Department.

J. Reasons for providing or authorizing a second opinion include, but are not limited, to the following:

1. The Member questions the reasonableness or necessity of recommended surgical procedures;
2. The Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including, but not limited to a serious chronic condition;
3. Clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/specialist/BH Provider is unable to diagnose the condition and the Member requests an additional diagnostic opinion;
4. The treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; and
5. The Member has attempted to follow the plan of care or consulted with the initial physician/BH Provider regarding serious concerns about the diagnosis or plan of care.

K. If the Member is requesting a second opinion about care from his or her PCP/BH Provider, the second opinion must be provided by an appropriately qualified physician/BH Provider.

L. If the Member is requesting a second opinion about care from a specialist, the second opinion must be provided by any physician of the same or equivalent specialty of the Member's choice, within the Alliance.

M. The plan reserves the right to limit a member's choice of provider for the second opinion from within the network/contracted providers when there is a qualified professional available. The member shall be referred outside when there is not an available/ qualified professional available.

N. The request to the practitioner that is performing the second opinion must include the timeframe for completion of the consultation and the requirements to be included in the consultation report.

O. The second opinion practitioner is responsible for submitting consultation reports to the Member, requesting practitioner, and PCP/BH Provider, within three working days of the visit.

P. If the second opinion is deemed urgent, the submission of the consultation report must be within 24 hours of the visit.

Q. Mandated timeframes for decision including approval, denial, or modification of a request for a second opinion and subsequent notification to the Member and practitioner are as follows:

1. Prior Authorization for Non-Urgent Second Opinions with Out-of-Network Providers:

    a. The prior authorization process is initiated when the Member's physician requests a second opinion.

    b. The timeframes for completion and adjudication of the second opinion are as follows:

        1). Practitioners have two days from the determination that a second opinion is necessary to submit the referral.

        2). The Alliance's decision to approve, modify, or deny must be made within five working days of obtaining only the information reasonably necessary to make a determination.

        3). If sufficient information is not available with the second opinion request, the Alliance contacts the requesting practitioner for the additional clinical information. The Alliance must annotate that additional information has been requested and must include the date of the request. A decision to approve, deny or defer must be made within the five calendar day timeframe.

        4). Practitioners must be initially notified within 24 hours of the decision by telephone or in writing. Telephonic communications of decisions must be

documented including date, time, name of contact person, and initials of the person making the call.

5). The Alliance must notify both the Member and practitioner in writing of all decisions, within two working days of the decision.

2. Prior Authorization of Urgent Second Opinions with Out-of-Network Providers:

   a. Practitioners must submit urgent requests for a second opinion the same day of the determination that the second opinion is necessary.

   b. Decisions regarding prior authorization for urgent second opinions and notification of decisions to practitioners must be completed within 72 hours of the receipt of the request.

   c. Practitioners are notified of the decision by telephone or in writing within 24 hours of the decision and not to exceed 72 hours of receipt of request. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

   d. Notification must be made to the Member and practitioner, in writing, within 72 hours of receipt of the request. If verbal notification is given within 72 hours of receipt of request, written or electronic notification must be given no later than three calendar days after the initial verbal notification.

   e. Both the Member and practitioner must be notified of how to file an expedited review at the time they are notified of the denial.

3. Inpatient Second Opinions:

   a. Requests for second opinions for Members in an inpatient setting at the same facility do not require prior authorization.

   b. A request for second opinions for Members in an inpatient setting at a different facility, which requires the members to be transferred, requires authorization. Practitioners must be initially notified within 24 hours of the decision by telephone. If the practitioner cannot be reached by telephone, a fax can be utilized. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

   c. The practitioner must be notified of denials in writing within 24 hours of the receipt of the request. If verbal notification is given within 24 hours of request, then written/ electronic notification must be given no later than three calendar days after verbal notification.

   d. Notification must be made to both the Member and practitioner on how to file an expedited review.

4. Expedited Review:

   a. If the practitioner receives a denial for an urgent or inpatient second opinion request, the practitioner can request an expedited review by contacting the Alliance's Chief Medical Officer or Medical Director.

   b. If the Member receives a denial for an urgent or inpatient second opinion request, the Member can request an expedited review by contacting the Alliance's Member Services Department.

   c. Timeframes for decisions and notifications of the decisions to the Member and the practitioner regarding the expedited review are as follows:

      1). Decisions must be made within 72 hours of the initiation of the

expedited review and both the Member and the practitioner must be notified within one day after the decision is made.

5. Written confirmation of the decision must be provided to the Member and the practitioner within two working days from notification of the decision if the decision was not previously made in writing.

Q. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 Delegation Oversight.

DEFINITIONS / ACRONYMS

None

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 UM Program
UM-057 Authorization Service Requests
BH-002 Behavioral Health Services
CMP-019 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHE ATTACHMENTS

NONE

REVISION HISTORY

2/27/2001, 1/1/2008, 10/28/2009, 9/15/2011, 6/14/2012, 7/14/2013, 1/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 7/17/2024

REFERENCES

1. California Health & Safety Code, Section 1383.15
2. 42 CFR Section 438.206

MONITORING

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

POLICY AND PROCEDURE

Policy Number	UM-007
Policy Name	New and/or Experimental Technology Review Process
Department Name	Medical Services
Department Chief	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	7/17/2024

POLICY STATEMENT

Alameda Alliance for Health (the Alliance) has an established mechanism for reviewing new and/or experimental technology as well as a new application of existing technology. The Alliance's process for reviewing new and/or experimental technology complies with standards set by Title 42, CFR, §422.202(b).

The intent of the evaluation of new developments in technology and new applications of existing technology is to ensure that Alliance members have equitable access to safe and effective care.

The Alliance reviews new technology and new application of existing technology for inclusion in plan benefits. This review encompasses the following:

- Medical procedures
- Behavioral healthcare procedures
- Pharmaceuticals
- Devices

The Alliance's new technology evaluation process will include:

- The process and decision variables the plan uses to make determinations, including review of:
    - Member access to services
    - Utilization patterns
    - Patient safety
    - Provider consistency in scope of utilization requests
- A review of information from appropriate government regulatory bodies, including the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), and the Centers for Medicare and Medicaid Services (CMS).
- A review of information from published scientific evidence.

- Obtaining input from relevant specialists and professionals with expertise in the technology.
- The Alliance's coverage decisions will be based on an assessment of new technology and new applications of existing technology, or on a review of special cases.

PROCEDURE

1. Review and assessment of new and/or experimental technology is the sole responsibility of Alameda Alliance for Health in concert with State and Federal regulatory requirements and is not delegated to any health care partner or Delegated Medical Group. The process is designed to address recognizing and evaluating advances in medical, pharmaceutical, and behavioral health care technologies and includes review of the following:
    i) Medical and Surgical procedures, including transplants
    ii) Drugs and pharmaceuticals
    iii) Behavioral healthcare procedures
    iv) Diagnostic and screening tests
    v) Alternative therapies
    vi) Medical devices/equipment
    vii) Clinical interventions

2. Formal medical policy review (including medical, behavioral health and pharmacy) is conducted once a year using a two-step process requiring input from the Alliance Health Quality Improvement Health Equity Committee (QIHEC). The first step in the process is to propose the technologies and changes to technologies to be evaluated and the second step is the actual revision of existing, or creation of new, policies. The QIHEC is the approving body in both steps. Special case reviews are conducted throughout the year and are approved by the CMO in accordance with review processes and timelines. The information from those special case reviews is used as input into the routine, formal process. The information from both processes is used for benefit determinations and coverage decisions.

3. In preparing for the policy review, the UM Medical Director will coordinate the collection of necessary information about new and/or experimental technology and new uses of existing technology for review by the CMO, who will then propose to the QIHEC the subject areas to be evaluated:

    The CMO will obtain input from the (QIHEC) and the Pharmacy and Therapeutics Committee (P&T) for specific subjects and recommendations for review of new and/or experimental technology that should be considered for benefit coverage policy development.

4. The UM Medical Director will provide the proposed list of services and technologies to the CMO along with a summary and rationale for why the services should be evaluated. The CMO will present the list to the QIHEC for discussion and approval.

5. Once the QIHEC approves the list of subject areas, the Alliance UM Medical Director, Pharmacy Director, or Behavioral Health (BH) Director will develop coverage policies that support decisions about use of new technology and new application of existing technology.
    a. The UM Medical Director, with Medical Management Department staff (including pharmacy and behavioral health staff where relevant), will review all relevant research on the service, technology, or procedure, from available resources.

6. The Alliance uses appropriate industry resources to develop unbiased, evidenced-based assessments of the safety and efficacy of new, emerging, and controversial health technologies and evaluation of the impact of these technologies on healthcare quality, utilization, and cost.

7. The CMO, and the appropriate Medical Directors will identify benefit topics for which coverage policy development is indicated, i.e. sufficient benefit guidance/criteria for new or experimental technology are lacking.

8. The UM Medical Director, Pharmacy Director and BH Director will develop an initial assessment for specific each new or experimental technology topic consisting of an evaluation of scientific evidence to form conclusions about the benefits/risks of a particular device, therapy, procedure, diagnostic test, or preventive strategy in relation to its potential clinical use for a defined group of individuals.

9. The CMO reviews the draft coverage policies that are developed and presents the review of new and/or experimental technology research findings to the QIHEC (and P&T for applicable pharmaceutical technology) for discussion and decision.

10. The UM Medical Directors will draft the Coverage Policy Statement for CMO review and approval.

11. Following CMO approval, each Coverage Policy Statement will be:
    i) Made available to providers through:

        (1) Announcement of policy publication and availability in the next scheduled Provider Bulletin
            (a) Contacting the UM Department at to request policy copies
            (b) Posting on Alliance website Provider Portal (when feature is available).

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.

DEFINITIONS

Experimental Service: According to Title 22, CCR, Section 51056.1, an experimental service is any drug, equipment, procedure, or service that is in the testing phase undergoing laboratory and/or animal studies prior to testing in humans.

Investigational Service: According to Title 22, CCR, Section 51056.1, an investigational service is any drug, equipment, procedure, or service for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

a. Testing is not complete; and

b. The efficacy and safety of such services in human subjects is not yet established; and

c. The service is not in wide usage.

Technology Assessment - A process established to evaluate the appropriate use of new technologies, new applications of existing technologies and the organizational or supportive systems within which such care is delivered. Services, procedures, pharmacological treatments, and behavioral health procedures are reviewed.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CMP-019 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 6/12/2012, 4/25/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 7/17/2024

REFERENCES

NCQA UM 10 Evaluation of New Technology
Title 42, CFR, Section 422.202(b)

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	UM-011
Policy Name	Coordination of Care - Hospice Services and Terminal Illness
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

Hospice

A. Hospice services will be provided in a timely manner, preferably within 24 hours of request, to any member who receives a physician's certification that the member has a terminal illness and who then elects hospice services.

B. Members who qualify for, and elect hospice remain enrolled in the Alliance while receiving these services.

C. Hospice Care is not Long-Term Care (LTC) regardless of the Member's expected or actual length of stay in a nursing facility.

D. The "election period" for hospice services consists of the following: (1) an initial 90 day period; (2) a subsequent 90 day period; or (3) an unlimited number of 60 day periods.

E. These services include, but are not limited to:

1. Nursing services.
2. Physical, occupational, or speech language pathology.
3. Medical social services under the direction of a physician.
4. Home health aide and homemaker services.
5. Medical supplies and appliances.
6. Drugs and biological.
7. Physician services

8. Counseling services related to the adjustment of the member's approaching death; counseling, including bereavement, grief, dietary and spiritual counseling.
9. Continuous nursing services may be provided on a 24-hour basis only during periods of crisis as necessary to maintain the terminally ill member at home.
10. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing, or hospice facility.
11. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing, or hospice facility.
12. Any other palliative item or services for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.

F. Prior Authorization may not be required for routine home care, continuous home care, respite care, or hospice physician services. The Alliance may require documentation, for reasons of justification, following the provision of general inpatient care.

G. Hospices shall notify the MCP of general inpatient care placement that occurs after normal business hours on the next business day.

H. Members are informed of the availability of Hospice Care as a covered service and the methods by which they may elect to receive these services through their Combined Evidence of Coverage and Disclosure Forms (EOCs).

I. The hospice provider will notify the plan when a plan member residing in a nursing home paid by Medi-Cal elects the Medi-Cal hospice benefit. See APL 13-014 for reimbursement guidelines.

J. Services not covered by a hospice provider include:
1. Private pay room and board or residential care
2. Acute in-patient hospitalization unrelated to the terminal illness
3. Level A or B nursing facility (NF) for unrelated issues
4. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
5. Other necessary services for conditions unrelated to the terminal illness.

K. CCS clients with a certified life expectancy of 6 months or less, who have elected hospice care, and request continuing treatment of the condition on which their hospice eligibility is based, may continue to receive CCS medically necessary concurrent non-palliative services. See MMCD Policy Letter PL 11- 004.

Terminal Illness

The Alliance will comply with CA Health and Safety Code regulatory guidance when making service request decisions for enrollees who have been diagnosed with a terminal illness.

PROCEDURE

Hospice

A. Hospice Care shall be limited to Members who have been certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.

B. A Member who elects to receive Hospice Care must file an election statement with the hospice providing the care. The election statement shall include:

1. Identification of the hospice;
2. The Member's or representative's acknowledgement that:
    a. There is a full understanding that the hospice care given as it relates to the Member's terminal illness will be palliative rather than curative in nature.
    b. Certain specified Medi-Cal benefits are waived by the election.
3. The effective date of the election;
4. The signature of the Member or representative.

C. A Member's voluntary election may be revoked or modified at any time.

1. The Member must file a signed statement with the hospice revoking the Member's election for the remainder of the election period;
2. A Member or representative may:
    a. Execute a new election for any remaining entitled election period at any time after revocation;
    b. Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.

D. Alliance Care Coordination/ Utilization Management is required to arrange for the continuity of medical care, including maintaining established Member-Provider relationships, to the greatest extent possible.

E. If the member is residing in a Long-Term Care Facility

1. Section 1905(o)(1)(A) of the SSA allows for the provision of hospice care while an individual is a resident of a nursing facility (NF) or Intermediate Care Facility for the Developmentally Delayed (ICF/DD). Payment will be provided to the hospice agency directly.
2. The hospice will then reimburse the NF for the room and board at the rate negotiated between the hospice and the NF
3. Dual eligible members the hospice shall notify the MCP when a member elects Medicare hospice benefit. The MCP will then pay the room and board payment to the hospice provider.
    a. Eligibility for nursing facility room and board will be determined by the MCP and the nursing facility.

Terminal Illness

A. The Alliance shall provide the following information to an enrollee with a terminal illness within five (5) business days of a denial coverage for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider:

1. A statement setting forth the specific medical and scientific reasons for denying coverage.

2. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
3. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.

B. Upon receiving a complaint form requesting a conference pursuant to paragraph (3) of subdivision (a) of CA Health and Safety Code §1368.1 (b), the plan shall provide the enrollee, within 30 calendar days, an opportunity to attend a conference:
   1. To review the information provided to the enrollee pursuant to paragraphs (1) and (2) of CA Health and Safety Code §1368.1 subdivision (a);
   2. Conducted by a plan representative having authority to determine the disposition of the complaint;
   3. The plan shall allow attendance, in person, at the conference, by an enrollee, a designee of the enrollee, or both, or, if the enrollee is a minor or incompetent, the parent, guardian, or conservator of the enrollee, as appropriate;
   4. However, the conference required by CA Health and Safety Code §1368.1 subdivision (a) shall be held within five business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date.

C. Guidelines to Identify a Terminally Ill Diagnosis or Condition
   1. The Alliance uses written utilization review criteria based on sound medical evidence, consistently applied, regularly updated, and annually reviewed and approved by the Quality Improvement Health Equity Committee (QIHEC)
   2. MCG (formerly Milliman Care Guidelines) Guidelines are licensed and approved for use as a primary reference in the medical necessity decision making process. Other applicable publicly available guidelines from recognized medical authorities are referenced, when indicated.
   3. Of the four levels of hospice care as described in Title 22, CCR, Section 51349 only general inpatient care is subject to prior authorization. Documents to be submitted for authorization include:
      1) Levels of Care
         (a) Routine home care
         (b) Continuous home care requiring a minimum of eight hours of care per 24-hour period
         (c) Respite care provided on an intermittent non-routine, and occasional cases for up to five consecutive days at a time
         (d) General Inpatient care for pain and symptom control
            i. Documents to be submitted for authorization include:
               1. Certification of physician orders for general inpatient care.
               2. Justification for this level of care.
   4. The Alliance's policies shall conform to the statutory definition of terminal illness: "Terminally ill means the individual has a medical prognosis that his or her life

expectancy is 6 months or less if the illness runs its normal course."

D. Communication of Denial Determination

1. Requesting provider and Member written notifications for denied requests related to a terminal illness will include a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decision regarding medical necessity.
2. The denial Notice of Action (NOA) letter includes statements about the specific medical and scientific reasons for denying coverage.
3. The denial NOA letter will include, if appropriate, a description of alternative treatment, service, or supply covered by the Alliance.

DEFINITIONS / ACRONYMS

A. Terminally ill is defined in:

1. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.
2. CA Health and Safety Code § 1368.1(a) as an incurable or irreversible condition that has a high probability of causing death within one year or less.

B. Hospice Care is defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.

C. Palliative care means that hospice care given as it relates to the individual's terminal illness will be palliative rather than curative in nature. Interventions focus primarily on reduction and abatement of pain and other disease-related symptoms rather than interventions aimed at investigation and/or cure or prolongation of life. See Health and Safety Code §1339.31(b)

D. Crisis is the period in which the member requires continuous care for as much as 24-hours to achieve palliation or management of acute medical symptoms. Care provided requires a minimum of eight hours of primarily nursing care within a 24-hour period commencing at midnight and terminating on the following midnight. The eight hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is needed.

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

None

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENT

None

REVISION HISTORY

1/1/2008, 10/28/2009, 8/30/2012, 10/30/2013, 3/04/2015, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 10/19/2023, 12/18/2024

REFERENCES

A. CA Health and Safety Code §1368.1(a) (b)
B. DHCS Contract, Exhibit A, Attachment 10, Provision 8.C.
C. CCS NL: 04-0207 Palliative Options for CCS Eligible Children
D. CCS NL: 06-1011 Authorization-Concurrent Treatment for CCS Clients Who Elect Hospice
E. MMCD All Plan Letter 13-014 Hospice Services and MCMC
F. MMCD Policy Letter 11-004 ACA –Concurrent Care for Children
G. Title 22, CCR, Sections 51180 and 51349
H. Social Security Act §1905(o)(1)

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	UM-015
Policy Name	Emergency Services and Post-Stabilization Services
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Senior Director, Health Care Services
Lines of Business	MCAL, IHSS
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	8/21/2024

POLICY STATEMENT

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

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

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

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

    a. The Alliance maintains a process to receive notification of emergency room evaluations and subsequent admissions, whether voluntary or involuntary, 24-hours a day, 7 days a week.
    b. UM Staff is available 24 hours, 7 days a week for providers seeking authorizations for post-ER stabilization care. Calls after hours are triaged by

Alliance clinical staff. Staff is also available on the weekends and holidays during the daytime for assistance with discharge planning and transfers to step down facilities.

5. The Alliance ensures providers are reimbursed for emergency services and care provided to enrollees, until the care results in stabilization of the enrollee.
    a. A Physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

    b. The Alliance maintains a process to approve or disapprove requests for necessary post-stabilization medical care within one half hour (30 minutes) of the request.
        i. If The Alliance fails to approve or disapprove a health care Provider's request for authorization to provide medically necessary post- stabilization care services within one half hour of the request, the Medically Necessary post-stabilization care services are deemed as authorized.
    c. The Alliance maintains documentation of all requests for authorization and responses to such requests for post-stabilization medically necessary care.

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

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

8. The Alliance ensures that providers are reimbursed for emergency services and care provided to enrollees, until the care results in stabilization of the enrollee and
    a. The Alliance shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical/mental health condition.
    b. The Alliance maintains processes to ensure that providers are reimbursed for emergency services and care provided to its enrollees in and out of service areas, until the care results in stabilization of the enrollee
    c. The Alliance reimburses providers for emergency services and care provided to its enrollees until the care results in stabilization of the enrollee and does not require a prior authorization for that reimbursement.
    d. The Alliance may deny reimbursement to a provider if:
        i. The Member is not eligible for services at the time the service was rendered.
        ii. The Member was admitted to the same hospital and ER facility charges are included in the Hospital claim.
        iii. The Alliance, or its contracting medical providers, reasonably determines that the emergency services and care were never performed
        iv. The Member did not require emergency services and care, and the Member

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

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

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

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

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

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

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

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

PROCEDURE

1. Alliance contracts stipulate that a PCP will be available 24 hours a day, seven (7) days a week for urgent/emergent requests from assigned members or from Emergency Department personnel about the PCP's members to/for:

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

    b. Authorize medically necessary post-stabilization services.

    c. General communication with emergency room personnel.

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

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

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

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

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

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

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

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

    a. No prior authorization is needed for emergency services.

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

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

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

        - For MediCal inpatient psychiatric admissions, Alliance will triage, screen, and refer admissions related to SED/SMI conditions admissions to Alameda County Behavioral Health Services.

        - For Group Care, inpatient psychiatric admissions are managed by Alliance BH staff or 24 hour triage line for assistance.

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

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

        i. Date and Time of Call

        ii. Member Demographics (Name, ID Number, DOB)

        iii. Requesting Facility Information

        iv. Caller Name and Contact Information

        v. Name of the health care provider making the request and Contact information

        vi. Request

vii. Name of the Alliance representative responding to the request

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

i. Working Diagnosis

ii. Vital Signs

iii. Chief Complaints and symptoms such as bleeding, chest pain, impaired neurological status

iv. How the member was brought into the ED such as ambulance, paramedics, police transport, or employer, parent, spouse, friend, or self-transport.

v. Duration of the condition such as sudden onset or length of days or weeks.

vi. Treatment or services already provided such as suturing, injections, medications, IV fluids, oxygen.

vii. Procedures or tests already conducted such as chest-tube insertion, x-rays, MRI, laboratory work.

viii. Actual or suggested type of discharge from the Emergency Department such as hospital admission, transfer to another facility, discharge home with instructions and follow-up by PCP/BH Provider.

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

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

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

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

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

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

ii. When agreement is made to accept the admission, The Alliance UM/BH Staff or the delegated Provider Group will issue the authorization for the admission.
iii. When post-stabilization services are denied and the agreement is made to discharge the Member from the emergency department, the UM Staff are responsible for ensuring the ER follow up care is in place, authorizations noted, transportation needs addressed and follow up communication is made to the PCP/Provider Group.
iv. When post-stabilization services are denied and the agreement is met and transfer to an in-network hospital is made, the Alliance UM Staff is responsible for the coordination of all necessary services to safely transfer the Member based on the identified needs.
v. For denied post-stabilization care, the Alliance or its delegates are not obligated to pay for the continuation of such care from and after the time it provides such notice to the provider. The Alliance should take into consideration the care necessary to effect the enrollee's transfer or discharge so as not to have an adverse impact upon the efficacy of such care or the enrollee's medical condition.

7. Ambulance services are to be covered when:
    a. 911 emergency response system is activated for a condition the member reasonably believed was emergent.
    b. Ambulance Services to transfer to appropriate facility, the attending physician should identify the type of transportation most appropriate to manage the Member's condition.

8. Delegate Networks are required to adhere to all Emergency Service requirements including 24/7 availability of medical staff to authorized medically necessary post stabilization care and coordinate transfer of stabilized Members to an appropriate network provider, if necessary.

DEFINITIONS

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

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

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

Emergency Services –

4. As defined by Centers for Medicare and Medicaid (CMS), are health care services provided to evaluate and stabilize medical/behavioral health conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson with

average knowledge of medicine and health to believe that failure to get immediate medical care could result in:

a. serious jeopardy to the health of an individual or, in the case of a pregnant woman, the health of the woman or unborn child;
b. serious impairment to bodily functions;
c. serious dysfunction of any bodily organ or part, or
d. serious disfigurement.

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

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

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

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

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

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

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

Red = Substantive Updates

REFERENCES

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

MONITORING

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

ALAMEDA Alliance FOR HEALTH
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Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-018
Policy Name	Targeted Case Management (TCM) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens)
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Director, Utilization Management
Lines of Business	MCAL
Effective Date	11/21/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Medi-Cal for Kids and Teens) for individuals 21 years of age or older: services are determined to be medically necessary when it is reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain are covered by AAH. For individuals under 21 years of age, services must meet the standards set forth in Section 1396(5) of Title 42 of the US Code., which includes: screening services, vision, dental and hearing services.

B. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services, defined as any service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of the AAH contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

C. A service does not need to cure a condition in order to be covered under EPSDT (Medi-Cal for Kids & Teens.) Services that maintain or improve the child's current health condition are also covered under EPSDT (Medi-Cal for Kids & Teens,) because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable or to make

better." Additional services are provided if determined to be medically necessary for an individual child.

D. At AAH, medical necessity decisions are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not permitted. AAH does not impose service limitations on any EPSDT (Medi-Cal for Kids & Teens,) covered service other than medical necessity. The determination of whether a service is medically necessary or a medical necessity for an individual child is made on a case-by-case basis, taking into account the particular needs of the child.

E. Pursuant to WIC Section 14059.5(b)(1), for individuals under 21 years of age, a service is considered "Medically Necessary" or a "Medical Necessity" if the service meets the standards set forth in federal Medicaid law for EPSDT (Title 42 of the USC Section 1396d(r)(5)). Therefore, an EPSDT (Medi-Cal for Kids & Teens,) covered service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions. AAH applies this definition when determining if a service is medically necessary or a medical necessity for any Member under the age of 21.

F. Coverage of preventive care and screenings must be conducted with evidence-informed, comprehensive guidelines as outlined by Bright Futures/the American Academy of Pediatrics (AAP) AAH uses the current AAP Bright Futures periodicity schedule and guidelines when delivering care to any Member under the age of 21, including but not limited to screening services, vision services, and hearing services. AAH provides all age-specific assessments and services required by the DHCS Contract and the AAP/Bright Futures periodicity schedule. AAH provides any medically necessary EPSDT (Medi-Cal for Kids & Teens,) services that exceed those recommended by AAP/Bright Futures.

G. AAH provides Members with appropriate referrals for diagnosis and treatment without delay. AAH is also responsible for ensuring Members under the age of 21 have timely access to all medically necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up. Services are initiated within timely access standards whether or not the services are Covered Services.

H. AAH provides case management and care coordination for all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services.

I. AAH exchanges necessary data for the provision of services as well as the coordination of non-covered services such as social support services.

J. The Alliance determines if a Medi-Cal Member requires EPSDT (Medi-Cal for Kids and Teens,) Case Management (CM) services through a participating local government agency or through an organization such as the Regional Center of the East Bay (RCEB).

K. AAH ensures the coverage of Targeted Case Management (TCM) services. The Alliance is responsible for assisting in the coordination of care for members who require Targeted Case Management (TCM) services to a Regional Center or local governmental health program. The Alliance is responsible for coordinating the member's health care with the TCM provider.

L. The Alliance will determine the medical necessity of diagnostic and treatment services recommended by the TCM provider and covered under the contract and will authorize approved services. If AAH determines that a Member is not eligible for TCM services, AAH will ensure that the Member's access to services is comparable to EPSDT (Medi-Cal for Kids & Teens,) TCM services.

M. For Members under the age of 21, AAH provides and covers all medically necessary EPSDT (Medi-Cal for Kids & Teens,) services except those services that are specifically carved out of the DHCS Contract and not included in AAH's capitated rate. Carved-out services include, but are not limited to, California Children's Services (CCS) Program, dental services, Specialty Mental Health Services, and Substance Use Disorder Services.

N. The plan will provide and pay for EPSDT (Medi-Cal for Kids and Teens,) supplemental services, except for those services provided under California Children Services (CCS) and those targeted case management services (TCM) receiving funding through other mechanisms (dental, specialty mental health services and Substance Use Disorder Services)

O. The Alliance will provide access to medically necessary diagnostic and treatment services, including but not limited to BHT (Behavioral Health Treatment) services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist. AAH provides medically necessary Behavioral Health Treatment (BHT) services consistent with the requirements in APL 23-005, for eligible Members under the age of 21.

P. The Alliance will provide appointment scheduling assistance if needed and necessary non-emergency medical transportation (NMT) for services.

Q. The Alliance must inform members or their families about EPSDT, (Medi-Cal for Kids and Teens,) how to obtain services, transportation, health education, anticipatory guidance (members under 21) in the members' primary language.

PROCEDURE EPSDT (Medi-Cal for Kids and Teens) Services

A. Member needs for EPSDT (Medi-Cal for Kids and Teens,) Services are determined primarily through initial and periodic health assessments by the Member's PCP in accordance with Child Health and Disability Prevention Program (CHDP) required services. The need for EPSDT (Medi-Cal for Kids and Teens,) supplemental services may also be identified by the Member, the Member's parent or other family members, through a Member's encounter with a health care practitioner, or from the Utilization Management staff while reviewing prior authorization requests.

B. If a PCP, specialist Alliance case manager identifies the need for a health care service for a Member under age 21 that is not covered by the Alliance, the service may be available as an EPSDT (Medi-Cal for Kids and Teens,) service. The PCP or specialist must request the services from the Alliance and document the rationale for the request in the medical record. Alliance Utilization Management (UM) will assess if the service is medically necessary, regardless of whether or not it is a defined benefit.

C. Examples of EPSDT (Medi-Cal for Kids and Teens,) Supplemental Services are: cochlear

implants, EPSDT (Medi-Cal for Kids and Teens,) CM services and EPSDT (Medi-Cal for Kids and Teens,) supplemental nursing services. EPSDT (Medi-Cal for Kids and Teens,) services also include additional services beyond those otherwise limited to two-per-month with Medi- Cal. These services include psychology, chiropractic, occupational therapy, speech therapy, audiology, and acupuncture.

EPSDT (Medi-Cal for Kids and Teens,) Nursing Services

A. EPSDT (Medi-Cal for Kids and Teens,) nursing services include hourly or shift nursing services provided by or under the supervision of licensed, skilled nursing personnel in a Member's residence or in a specialized foster care home.

EPSDT (Medi-Cal for Kids and Teens,) Case Management (CM) Services

A. Alliance CM is required to provide all necessary CM services for Members accessing EPSDT (Medi-Cal for Kids and Teens,) supplemental services including at a minimum:
    1. Arranging for all approved services including out-of-network practitioners as needed;
    2. Coordination of care between all practitioners (PCPs, specialists, other EPSDT (Medi-Cal for Kids and Teens,) providers);
    3. Transferring medical information as necessary between practitioners; and
    4. Developing a specific care plan for the Member as needed.

B. Alliance UM/CM staff are responsible for assessing a Member's need for EPSDT (Medi-Cal for Kids and Teens,) CM services. The criteria to be used in determining the necessity for EPSDT (Medi-Cal for Kids and Teens,) CM services include whether or not:
    1. The Member has a complicated medical condition and/or behavioral health condition resulting in significant impairment.
    2. The Member has one or more environmental risk factors (primary care giver under 18 years or primary care giver has a disability).
    3. Any environmental stressors would compromise the primary care giver's ability to assist the Member in gaining access to necessary medical, social, educational, or other services.

C. Alliance CM must determine if the Member is eligible or is already receiving targeted CM through a participating local governmental agency or through an entity or organization including but not limited to the following:
    1. RCEB
    2. Children's Hospital
    3. City of Fremont – Linkages
    4. City of Fremont - FFRC
    5. City of Oakland
    6. Covenant House California
    7. Public Health Department
    8. Roots Community Health Center
    9. Probation Department
    10. Tiburcio Vasquez Health Center

    If the Member receives targeted CM through one of these entities, the Alliance CM will coordinate care with the case manager from the agency and coordinate

determination of medical necessity of diagnostic and treatment services covered by the Alliance. The Alliance CM will share minimum necessary information with the entity to ensure the specific needs of the member at met, through secure resources (for example, but not limited to, secure email or sFTP shared site).

D. Specialized EPSDT (Medi-Cal for Kids and Teens) CM services may be provided by a Targeted Case Management (TCM) entity (e.g., RCEB), a child protection agency, other agencies or entities serving children, or an individual practitioner whom the Alliance finds qualified by education, training, or experience to provide specialized CM services. Alliance CM is responsible for arranging the necessary case management for Members.

E. If a Member receives TCM or specialized EPSDT (Medi-Cal for Kids and Teens) CM services, Alliance CM is required to coordinate those services with the PCP and/or specialist practitioner. This includes coordination with RCEB CM as well as any other agencies' CM staff providing the services.

F. EPSDT (Medi-Cal for Kids and Teens) CM services may be provided by the Alliance, RCEB, Child Protective Services, or the Department of Mental Health as needed.

Targeted Case Management Services

A. The Alliance and PCPs are responsible for determining whether members require Targeted Case Management (TCM) services, and for referring members who are eligible for TCM services to RCEB or the local government health program as appropriate for the provision of TCM services.

1. The Alliance maintains a Memorandum of Understanding (MOU) with Regional Center of the East Bay (RCEB) and Alameda County for the purpose of specifying the division of responsibilities between the two organizations and detailing guidelines for the provision of targeted case management for Medi-Cal members enrolled in the Alliance.

B. TCM services provided by RCEB include at least one of the following, as described in Title 22, CCR, Section 51351:

1. A documented assessment identifying the member's needs;
2. The development of a comprehensive, written, individual service plan, based upon the assessment;
3. The implementation of the service plan, which includes linkage and consultation with and referral to providers of service;
4. Assistance with accessing the services identified in the service plan;
5. Crisis assistance planning to coordinate and arrange immediate services or treatment needed in those situations that appear to be emergent in nature; and
6. Periodic review of the member's progress toward achieving the service outcomes identified in the service plan;

C. If a member is receiving TCM services as specified in Title 22, CCR, Section 51351, the Alliance is responsible for coordinating the member's health care with the TCM provider and for providing Care Coordination for all Medically Necessary Covered Services identified by the TCM Providers in their Member care plans, including referrals and Prior Authorization for Out-of-Network medical services.

1. This coordination continues until the TCM provider notifies the Alliance that TCM services are no longer needed for the member.

2. The Alliance is responsible for coordinating the provision of services, including TCM, with the other entities to ensure that the Alliance and other entities are not providing duplicative services.

a. This process includes but is not limited to: contacting the other entity, assessing for services provided by the other entity, and communication with the other entity regarding the delegation of services needed by the member.

D. The Alliance designates an RCEB liaison responsible for coordinating TCM services with RCEB and local government agencies, if needed.

1. Responsibilities of the liaison include, but not limited to: sharing appropriate member provider(s) information, PCP information, care manager assignment with RCEB and local government agencies as needed, and resolving all related operational issues

a. The Alliance notifies member's PCP and/or care managers when members are receiving TCM services and provides them with appropriate local governmental agency contact information.

E. For members under the age of twenty-one (21), not accepted by RCEB for TCM services, the Alliance ensures that they have access to comparable EPSDT (Medi-Cal for Kids and Teens,) TCM services.

Behavioral Health Services

A. The provision of EPSDT (Medi-Cal for Kids and Teens,) services for members under 21 years of age, which includes medically necessary, evidence-based BHT services that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, will become the responsibility of the Alliance:

1. Effective on the date of the member's transition from the RC
2. For new members, upon MCP enrollment

B. Criteria for BHT Services:

1. Be under 21 years of age.
2. Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.
3. Be medically stable.
4. Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

The Alliance is responsible for coordinating the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services

C. BHT Covered Services:

1. Medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist.
2. Delivered in accordance with the member's MCP-approved behavioral treatment plan.
3. Provided by California State Plan approved providers as defined in SPA 14-026.9 4) Provided and supervised according to an MCP-approved behavioral treatment plan developed by a BHT service provider credentialed as specified in SPA 14-026 ("BHT Service Provider").

D. BHT services are provided under a behavioral treatment plan:

1. The BHT treatment plan must have measurable goals over a specific timeline for the specific member
2. The BHT treatment plan must be developed by a BHT Service Provider.
3. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider.
4. The behavioral treatment plan may be modified if medically necessary.
5. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

E. Services that do not meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:
   1. Services rendered when continued clinical benefit is not expected.
   2. Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
   3. Treatment whose sole purpose is vocationally- or recreationally-based.
   4. Custodial care. For purposes of BHT services, custodial care:
      a. Is provided primarily for maintaining the member's or anyone else's safety.
      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, legal guardian, or legally responsible person.
   7. Services that are not evidence-based behavioral intervention practices.

F. The approved behavioral treatment plan must meet the following criteria:

1. Be developed by a BHT Service Provider for the specific member being treated.
2. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
3. Be person-centered and based upon individualized, measurable goals and objectives over a specific timeline.
4. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
5. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
6. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
7. Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
8. Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
9. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/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 BHT service provider responsible for delivering the services.
10. Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
11. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
12. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community.
13. Include an exit plan/ criteria.

G. Continuity of care:

1. The Alliance must automatically initiate the continuity of care process prior to the member's transition to the MCP for BHT services.
2. At least 45 days prior to the transition date, DHCS will provide the Alliance with a list of members for whom the responsibility for BHT services will transition from RCs to the Alliance, as well as member-specific utilization data. The utilization data file will include information about services and rendering providers recently accessed by members.
3. The Alliance will utilize the data and treatment information provided by DHCS, the RC, or the rendering provider to determine BHT service needs and associated rendering providers. This information should be used to determine if the current BHT provider is in the MCP's network and if a continuity of care arrangement is necessary.
4. The Alliance must make a good faith effort to proactively contact the provider to begin the continuity of care process.
5. The Alliance must offer members continued access to an out-of-network provider of BHT services (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL 18-008, if all of the following conditions are met:
    a. The member has an existing relationship with a qualified provider of BHT services. An existing relationship means the member has seen the provider at least one time during the six months prior to either the transition of services from the RC to the Alliance or the date of the member's initial enrollment in the Alliance if enrollment occurred on or after July 1, 2018.
    b. The provider and the Alliance can agree to a rate, with the minimum rate offered by the Alliance being the established Medi-Cal fee-for-service (FFS) rate for the applicable BHT service.
    c. The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the Alliance's network.
    d. The provider is a California State Plan approved provider.
    e. The provider supplies the Alliance with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and

regulations.

6. If a member has an existing relationship, as defined above, with an in-network BHT service provider, the Alliance must assign the member to that provider to continue BHT services.
7. BHT services should not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by the Alliance, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network Alliance provider.
8. If a continuity of care agreement cannot be reached with the RC provider by the date of transition to the Alliance, the Alliance must appropriately transition the member to a new, in-network BHT service provider and ensure that neither a gap nor a change in services occurs until such time as the Alliance approves a new assessment and behavioral treatment plan from an in-network BHT service provider.

OUTBOUND CALL CAMPAIGN:

To inform members who are transitioning from RCs of their automatic continuity of care rights, the Alliance must conduct an Outbound Call Campaign, as described below.

A. Call the member (or his/her parent/guardian) after 60-day member informing notices are mailed and prior to the date of transition.
B. Make five call attempts to reach the member (or his/her parent/guardian).
C. Inform the member of the transition and the continuity of care process.
D. Not call members who have explicitly requested not to be called.

REPORTING AND MONITORING:

The Alliance will report metrics to DHCS related to the requirements in a manner determined by DHCS.

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

EPSDT (Medi-Cal for Kids and Teens,) Supplemental Services: Services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or other condition that must be provided to an Alliance member under 21 years of age.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

REVISION HISTORY

1/1/2008, 10/28/2009, 4/1/2011, 8/30/2012, 01/10/2016, 12/15/2016, 7/19/2018, 8/3/2018, 09/06/2018, 11/21/2019, 7/31/20, 9/17/2020, 03/22/2022, 12/19/2023, 12/18/2024

REFERENCES

APL 18-008 Continuity of Care
APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21
APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21

DHCS Contract Exhibit A, Attachment 1, Provision 3 and 11
Title 22, CCR, Sections 51184, 51303, 51340, 51340.1, and 51351
Title 42, Section 1396d(R)(5)
Welfare and Institutions Code, CCR, Section 14132.44

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 (QIHEC) annually.

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

POLICY AND PROCEDURE

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

POLICY STATEMENT

General Guidelines

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

1. Standards for Obstetric Services and Guidelines and Oral Health Care during Pregnancy and Through the Lifespan from the American College of Obstetricians and Gynecologists (ACOG).
2. Guidelines for Perinatal Care, The American Academy of Pediatrics
3. Guide to Clinical Preventive Services, Report of the U.S. Preventive Services Task Force.
4. Newborn Screening regulations as set forth in Title 17, California Code of Regulations, Section 6500 et seq.
5. Comprehensive Perinatal Services Program (CPSP) regulations as set forth in Title 22.
6. Maternity Care Clinical Recommendations & Guidelines, AAFP

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

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

Obstetrical Care by Certified Nurse Midwives and Certified Nurse Practitioners

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

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

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

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

PCP Role in Care of Pregnant Members

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

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

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

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

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

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

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

Multi-Disciplinary Perinatal Services

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

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

PROCEDURE

General Procedures

A. **Accessing Perinatal Services**:

1. Once the PCP, Case Management or any other practitioner has established that the Member is pregnant, the Member may initiate prenatal care from an Alliance OB

Members may receive assistance from the PCP or Alliance Member Services in scheduling an appointment.

2. The initial prenatal visit must be made within one week of the request. Urgent prenatal visits must be scheduled the same day. Prenatal care should be initiated within the first trimester whenever possible. The initial prenatal visit may not be delayed for authorization.
3. Members may access basic support services without prior authorization. Basic services include the initiation of prenatal care visits, initial comprehensive risk assessment, all subsequent risk assessments each trimester, and low risk interventions conducted in the OB practitioner's office. Referrals for high-risk OB conditions, health education, nutrition, dental anesthesia, or psychosocial services are processed through the standard authorization process.

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

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

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

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

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

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

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

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

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

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

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

I. Ante partum Care

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

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

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

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

1. Genetic Screening:
    a. Each pregnant Member receives screening and assessment for genetic risk factors. Members assessed as at risk for genetic disorders receive counseling and referrals, as appropriate.
    b. The initial prenatal evaluation must include a risk assessment and screening for genetic risk factors. Included in the assessment is a maternal serum alpha- fetoprotein (MSAFP) screen between 16-18 weeks of gestation.
    c. Factors which place Members at risk include:
        - Advanced maternal age (mother 35 years or older at expected time of delivery)
        - Previous offspring with a chromosomal aberration
        - Chromosomal abnormality in either parent
        - Family history of a sex-linked condition
        - Ancestry indicating risk for Tay-Sachs, sickle cell anemia, or other hemoglobinopathies

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

M.

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

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

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

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

R. High Risk Obstetrical Care:

1. High risk OB Members must be referred for evaluation and care if beyond the scope of practice of the initial prenatal practitioner. High risk indicators (or markers) include:
    a. Evidence or history of asthma, gestational diabetes, pre-eclampsia, or eclampsia
    b. Indication of multiple fetuses
    c. Prior C-sections
    d. History of complicated deliveries such as placenta previa or abruption placenta
    e. History of pregnancy difficulties such as incompetent cervix
    f. Prior premature labor and/or delivery
    g. History of substance use/abuse
    h. Homelessness
    i. Under 18 or over 35 years of age.
2. The Alliance ensures that appropriate hospitals are available within the network to provide high-risk pregnancy services.

S. Intra-partum Care

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

T. Postpartum Care must include the following services:

1. A comprehensive postpartum review and examination is required between three and eight weeks after delivery. The postpartum assessment must include the following 4 components:
    a. Obstetric/medical exam: an interval history and physical examination to evaluate the Member's current condition that includes weight, blood pressure, breast exam, abdominal exam, external and internal genitalia evaluation, and laboratory tests, as necessary;
    b. Nutritional assessment: dietary intake of mom and infant feeding status, that includes evaluation of problems/needs of the breastfeeding mother;
    c. Psychosocial assessment: evaluation of Member's emotional status, resources, and available support system; and
    d. Educational needs assessment.
2. The development of an ICP and interventions as appropriate.
3. Family Planning Evaluation: This evaluation includes education on family planning and counseling, referral, and provision of services.
4. Referral to a pediatric practitioner for follow-up, as indicated.
5. Referral to the WIC program for State Program Members or Members that meet WIC's financial eligibility requirements (see Section 12E, "Referrals to the Supplemental Food Program for Women, Infants, and Children (WIC)").
6. Immunization information, including rubella, if appropriate.
7. Evaluation for special problems and return-to-work status, as indicated.
8. Referral to a Dentist for preventative care (exam/ cleaning) or therapeutic (extractions, fillings, abscess drainage, root canal), and to promote oral health for infants.
    a. <u>Medi-Cal Postpartum Care Extension (PCE) under the Provisions of American Rescue Plan Act (ARPA)"</u>
        - i. "Effective 4/1/2022, the Medi-Cal postpartum coverage period was extended from 60 days to 12 months for all Medi-Cal eligible pregnant individuals under the providers of the ARPA. The 12 month postpartum coverage period for Medi-Cal eligible pregnant individuals begins on the last day of pregnancy and will end on the last day of the month in which the 365th day occurs. ARPA PCE is an automatic postpartum extension"
        - ii. **"**Minor Consent beneficiaries do not qualify for ARPA PCE, as eligibility is month-to-month and cannot be applied automatically."
        - iii. The only allowable reasons that an individual can be discontinued from the ARPA PCE protections during their pregnancy and/or the 365-day postpartum period are as follows:
            - Death
            - Loss of California residency
            - Beneficiaries request for discontinuance
            - Receipt of Supplemental Security Income

- Aid on another Case

Certified Nurse Midwives/Certified Nurse Practitioners

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

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

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

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

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

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

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

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

PCPs

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

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

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

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

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

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

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

Multi-Disciplinary Perinatal Services

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

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

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

C. Basic perinatal support services are generally provided by one of the multi-disciplinary staff members in the perinatal practitioner's office. Examples of staff that can provide basic services include:

1. MD or DO
2. Nurse Practitioner
3. Certified Nurse Midwife
4. RN
5. LVN
6. Medical Assistant
7. Social Worker
8. Health Educator
9. Health Care Worker

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

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

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

G. . Perinatal support services for Members with high-risk conditions are generally provided outside the perinatal practitioner's office by licensed professionals including:

1. Registered Dietitian
2. Health Educator with master's level degree
3. MFCC or LCSW

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS / ACRONYMS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACMENTS

None

REVISION HISTORY

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

REFERENCES

1. DHCS Contract Exhibit A, Attachment 10. Provision 7
2. Title 22, CCR, Sections 51240, 51241, 51348, 51348.1
3. California Business and Professional Code 2725

4. W&I Code section 14132.24
5. Title 17, California Code of Regulations, Section 6500 et seq.
6. DHCS MMCD Policy Letter 12-003, Obstetrical Care-Perinatal Services
7. American Rescue Plan Act of the 117th Congress 2021-2022 (ARPA) (Pub. Law 117-2)

MONITORING

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

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

POLICY AND PROCEDURE

Policy Number	UM-029
Policy Name	Sensitive Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	1/1/2008
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	7/17/2024

/

POLICY STATEMENT

Family Planning

A. Family planning services are defined as services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy.

B. Pursuant to State and Federal requirements, Medi-Cal Members have the ability to self-refer, without prior authorization, to a qualified family planning practitioner within the Alliance Network, or self-refer to qualified Out-Of-Network family planning practitioners, also without prior authorization as described in the member's Explanation of Coverage handbook.

C. Pursuant to State and Alliance requirements Healthy Families and Non-State Program Members may self-refer without prior authorization, to a qualified family planning practitioner within the Alliance Network.

Sterilization

A. Pursuant to State and Federal requirements, Medi-Cal Members have the ability to self-refer, without prior authorization, to a qualified family planning practitioner within the Alliance network, or self-refer to qualified out-of-network family planning practitioners, also without prior authorization for sterilization services (tubal ligation or vasectomy).

B. Pursuant to State and Alliance requirements Healthy Families and Non-State Program Members may self-refer without prior authorization, to a qualified family planning practitioner within the Alliance network for sterilization services.

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

Sexually Transmitted Diseases

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

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

C. Healthy Families and Non-State Program Members may self-refer, without prior authorization to a qualified family planning practitioner within the Alliance Network.

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

E. Pursuant to California Health and Safety Code Section 120582, licensed physicians, nurse practitioners, certified nurse-midwives, or physician assistants who are practicing within their authorized scope of practice may prescribe, dispense, furnish, or otherwise provide prescription antibiotic medications to the sexual partner or partners of a Member with a diagnosed sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, without examination of the Member's sexual partner or partners.

HIV Testing and Counseling

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

B. Medi-Cal Members can access HIV testing and counseling as part of a family planning or STD visit, or at a LHD operated or contracted HIV testing site, without prior authorization.

C. Medi-Cal Members may access confidential HIV counseling and testing services from any network or out of network provider without obtaining a prior authorization.

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

Abortion Services

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

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

C. In order to access abortion services, Medi-Cal Members have the ability to self-refer, without prior authorization or medical justification, to a qualified practitioner

within or outside of the Alliance Network, when performed in an outpatient setting. The Alliance will not impose any utilization management or utilization review requirements on coverage of outpatient abortion services. The Alliance will not impose any annual or lifetime limits on the coverage of outpatient abortion services. Deductibles, coinsurance, copayments or any other cost-sharing requirements for an abortion or abortion-related services is prohibited and not required.

D. Non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization under the same criteria as other medical procedures.

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

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

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

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

PROCEDURE

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

B. Freedom of Choice

1. Members are to be provided with sufficient information to allow them to make informed choices regarding the types of family planning services available, and their right to access these services, including abortion services, in a timely and confidential manner. Medi-Cal Members are informed upon enrollment of their right to access family planning services and abortion services within and outside of Alliance's Network, without prior authorization. Healthy Families and Non-State Program Members are informed that access to family planning services and abortion services are available through any qualified obstetrical practitioner within the Alliance Network.

2. Members receive Family Planning and freedom of choice information from Alliance in the following ways:

   a. Member Explanation of Coverage Handbook;

   b. Member Newsletter; and

   c. Member Services contacts.

C. California Minor Consent

1. Minors of any age may consent to/receive Minor Consent Services from any Network Provider or Out of Network Provider without requiring Prior Authorization:

a. Family Planning services.

b. Medical care related to the prevention or treatment of pregnancy, except sterilization.

c. Birth control.

d. Abortion.

e. Emergency medical services when parent/guardian unavailable to give consent.

f. Medical care related to diagnosis, treatment and collection of medical evidence related to a sexual assault.

g. Medical care related to diagnosis, treatment and collection of medical evidence related to the rape of a minor under age 12.

2. Minors aged 12 and older may consent to/receive:

a. Medical care related to diagnosis, treatment of a sexually transmitted disease (STD).

b. An HIV test and diagnosis, treatment of HIV/AIDS.

c. Medical care related to diagnosis, treatment and collection of medical evidence related to an alleged rape.

d. Drug or alcohol abuse

e. Non-Specialty Mental Health Services, when mature enough to participate in their health care.

3. Minors are informed of the availability of Minor Consent Services without prior authorization in the Member Handbook/Evidence of Coverage.

D. Family Planning Services

1. The following list of services may be provided to Alliance Members as part of the family planning benefit, in or out of network, without prior authorization:

a. Health education and counseling necessary to make informed choices and understand contraceptive methods;

b. Verbal history and physical examination limited to immediate problem;

c. Laboratory tests, if medically indicated as part of decision making process for choice of contraceptive methods;

d. Follow-up care for complications associated with contraceptive methods issued by the family planning practitioner;

e. Provision of contraceptive pills, devices, supplies;

f. Provision and insertion of Norplant;

g. Tubal ligation;

h. Vasectomies;

i. Pregnancy testing and counseling;

j. Diagnosis and treatment of STDs if medically indicated (STD diagnosis and treatment, provided during a family planning encounter are considered part of family planning services); and

k. Screening, testing and counseling of at-risk individuals for HIV (HIV testing and counseling, provided during a family planning encounter, are considered part of family planning services).

2. Therapeutic and elective abortions are not considered a part of family planning services.

3. Infertility studies, reversal of voluntary sterilization, and hysterectomy for sterilization are not included under the Family Planning benefit.

4. Accessing Family Planning Services

   a. Medi-Cal Members select a qualified family planning practitioner of their choice within the Alliance Network, or Out-Of-Network. Alliance Member Services refers Members who request additional information to the State Office of Family Planning at (800) 942-1054 to receive more information on qualified family planning practitioners.

   b. Healthy Families and Non-State Program Members may self-refer without prior authorization, to a qualified family planning practitioner within the Alliance Network.

   c. AAH does not infringe upon any member's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required, including prior authorization, step therapy, or utilization control techniques.

   d. AAH defers to the determination and judgment of the provider and provides coverage for an alternative prescribed contraceptive drug, device, product, or service without imposing any cost sharing requirements if the covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by the member's provider.

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

   f. Members should be encouraged to approve release of their medical records from the family planning provider to the PCP so that the PCP may coordinate future care accordingly and avoid duplication of already provided services.

   g. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality, but allows STD service practitioners adequate information to bill for the services. Practitioners must make such a form available to Members.

5. Coordination of Care - Listed below are the roles and responsibilities of the PCP, Out-Of-Network family planning practitioner, the Provider and Alliance staff in coordinating care for Medi-Cal Members accessing Out-Of-Network practitioners for family planning.

   a. Out-of-Network practitioners should encourage Members to sign release of information forms so that clinical information can be forwarded to the Member's PCP. If a release is signed, and the Member needs care as a follow- up to the family planning services or due to a complication of the family planning service, the Out-Of-Network practitioner must contact the PCP. This applies to Medi-Cal Members only.

   b. The Member's assigned PCP is responsible for providing or coordinating any additional health care needed by the Member and/or documenting in the medical record any family planning services received by the Member (e.g., PAP smear, type of birth control method) upon receiving medical records from or being informed by the family planning practitioner or Member.

c. If informed by a family planning practitioner that follow-up is needed for a Member, the Alliance is responsible for informing the PCP and ensuring that all necessary follow-up or additional services are arranged for through the PCP or specialty practitioner as indicated.

6. Out-of-Network Family Planning Services Reimbursement (see Section 19 "Claims" for additional information).

F. Sterilization

1. Informed Consent.

a. Informed consent may not be obtained while the Member is under the influence of alcohol, or any substance that affects the Members state of awareness. Consent may not be obtained while the Member is in labor, within 24 hours of delivery, post abortion, or if the Member is seeking to obtain or obtaining an abortion.

b. Written informed consent must have been given at least 30 days and no more than 180 days before the procedure is performed. A copy of the consent form must be given to the Member.

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

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

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

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

2. Access to Sterilization Services

a. <u>For Medi-Cal Members</u>:

1). The Medi-Cal Member may select a qualified family planning practitioner of his/her choice within the Alliance network, or out of network. Members can call the State Office of Family Planning at (800) 942-1054 to receive more information on qualified family planning practitioners.

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

3). Out of network family planning practitioners must be reimbursed for covered family planning services when the following conditions are met:

i). The family planning practitioner must submit claims for sterilization services to the Member's Delegated Provider Group or the Alliance Claims Department on a CMS 1500 form, using the appropriate CPT and ICD-10 codes.

ii). The family planning practitioner must provide proof of service. If a Member refuses the release of medical information, the out-of-network practitioner must submit documentation of such a refusal.

iii). Proof of written informed consent must be submitted with the CMS 1500 form. The informed consent must have been given at least 30 days and no more than 180 days before the procedure is performed.

b. For Healthy Families Members:

Healthy Families Members do not have open access to Family Planning. Family Planning benefits are provided by the PCP or by self-referral to an Alliance practitioner. Prior authorization from the Alliance is required for care by an out- of-network practitioner.

c. For Non-State Members:

Non-State Members do not have open access to Family Planning. Family Planning benefits are provided by the PCP or by self-referral to an Alliance practitioner. Prior authorization from the Alliance is required for care by an out-of-network practitioner.

G. Sexually Transmitted Diseases

1. Access Within Network

a. Medi-Cal Members may elect to receive STD services from their PCPs or qualified practitioners within the Alliance Network.

b. Healthy Families and Non-State Program Members may elect STD services from their PCPs or qualified practitioners within the Alliance Network.

c. PCPs are required to offer all Members appropriate STD services, including screening, counseling, education, diagnosis and treatment.

d. Pursuant to Civil Code, Section 34.7, Members aged 12 and older may access STD services without parental consent.

2. Confidentiality and Reporting

a. The expressed, written consent of the Member or legal representative is required for the release of medical records to another party outside of the practitioner. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality but gives STD services practitioners adequate information for billing purposes. Practitioners must make such a form available to their Members.

b. All practitioners providing STD services are required by law to report individuals with certain communicable diseases to the LHD.

c. Medical records for Members presenting for STD evaluation must be maintained to protect the confidentiality of the Member. In-network practitioners must adhere to Alliance Medical Records policies and procedures.

3. Access Out-of-Network (This does not apply to Healthy Families and Non-State Program Members).

a. An Out-Of-Network practitioner is a practitioner who is not affiliated with Alliance for the provision of health care services. An Out-Of-Network practitioner may be a family planning practitioner, an LHD, or any other practitioner who provides STD services within their scope of licensure and practice. Members may access STD services through Out-Of-Network practitioners without prior authorization.

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

c. Out-of-network practitioners may call Alliance Member Services at (510) 747-4567 for Medi-Cal eligibility, benefits, benefit exclusions, limitations, and the name of the Member's Alliance PCP. Alliance reminds the Out-Of-Network practitioner to refer the Member back to their PCP to maintain continuity of care.

4. Coordination of Care

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

b. In those cases, the PCP is responsible for determining what services were received by the Member, recording or placing in the medical record all pertinent information (assuming consent from the Member) and determining any need for follow-up care, testing or treatment.

5. Reimbursement for Out-of-Network Services (This does not apply to Healthy Families and Non-State Program Members).

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

      1). Diagnosis and treatment of vaginal discharge and urethral discharge.

      2). Evaluation and initiation of treatment of Pelvic Inflammatory Disease (PID)

      3). Those STDs that are responsive to immediate diagnosis and treatment:

         i). Bacterial vaginosis

         ii). Candidiasis
         iii). Chancroid
         iv). Chlamydia
         v). Gonorrhea
         vi). Granuloma inguinale
         vii). Herpes simplex
         viii). Human papilloma virus
         ix). Lymphogranuloma venereum
         x). Non-gonococcal urethritis

         xi). Syphilis
         xii). Trichomoniasis

   b. For LHDs, reimbursement is available as outlined below:

      1). One visit is reimbursable for initiation of treatment of vaginal or urethral discharge for symptoms and signs consistent with bacterial vaginosis, trichomoniasis, or candidiasis.

      2). Initial visit and up to five (5) additional visits for clinical and serological follow-up and treatment of primary or secondary syphilis are reimbursable. Documentation should include serologic test results upon which treatment recommendations were made.

      3). Initial visit and up to two follow-up visits are reimbursable for confirmation of diagnosis and clinical improvement of chancroid.

      4). A maximum of three visits are reimbursable for lymphogranuloma or granuloma inguinale, based upon the time involved in confirming the diagnosis and the duration of necessary therapy.

      5). One visit is reimbursable for presumptive diagnosis and treatment of herpes simplex.

      6). Gonorrhea, non-gonococcal urethritis and chlamydia can often be presumptively diagnosed and treated in one visit. For individuals with gonorrhea or chlamydia not presumptively treated at the first visit, a second visit for treatment is reimbursed.

      7). One visit is reimbursable for diagnosis and initiation of therapy for human papilloma virus, with referral to PCP for further follow-up and treatment.

8). Initial visits and two follow-up visits for diagnosis, treatment and urgent follow-up of pelvic inflammatory disease are reimbursable. Members should be referred to their PCP for continued follow-up after the initial three visits have been provided by the LHD.

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

d. Guidelines for treatment of various STDs may require that HIV testing and counseling be performed. These tests and counseling procedures are reimbursed at the appropriate Medi-Cal FFS rate.

e. Conditions for Reimbursement

1). The Out-Of-Network practitioner must submit claims to the Alliance Claims Department on CMS 1500 or UB92 billing forms, using the appropriate CPT and ICD-10 codes that reflect STD diagnosis and treatment.

2). The STD treatment practitioner must provide proof of service. If a Member refuses the release of medical information, the treating practitioner must submit documentation of the refusal.

3). STD treatment practitioners are not reimbursed for services that fall outside the specific conditions and visits noted above.

4). STD practitioners are only reimbursed for services provided by a practitioner within their licensed scope of practice.

5). STD practitioners are only reimbursed for services provided to Alliance Medi-Cal Members.

f. Practitioners providing STD services who wish to register a grievance regarding non-payment, underpayment, or any billing related issue may do so by contacting:

NOPD Unit – Claims Department

Alameda Alliance for Health
PO Box 2460
Alameda, CA 94501-0460

H. HIV Testing and Counseling

1. Access to HIV Counseling and Testing Services Overview

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

1). As part of a well-child or adult physical exam.

2). At the time of a visit for illness or injury.

3). At the request of a Member, Member's parent or guardian.

4). Other appropriate circumstances.

b. The assessment by the PCP should include the following:
    1). Obtaining a sexual history in sufficient detail to assess risk.
    2). Discussing any history of substance abuse including use of needles.
    3). History of significant blood transfusions in the past during period of infected blood supply.
    4). If a newborn or young child, the history above for mother of the child.
c. For those Members identified by the PCP as at risk for HIV infection, one of the following must occur:
    1). PCP provides HIV testing and counseling.
    2). For Medi-Cal Members, either the PCP refers the Member, or the Member can self-refer to a LHD operated or contracted HIV testing and counseling site for confidential or anonymous services.
    3). For Healthy Families and Non-State Program Members, the PCP refers the Member to a LHD or contracted HIV testing and counseling site for anonymous testing services.
d. Medi-Cal Members can also access HIV testing and counseling services directly, without prior authorization:
    1). As part of a Family Planning visit with any qualified family planning practitioner.
    2). As part of an STD visit at a LHD or other qualified practitioner
    3). Direct self-referral for anonymous or confidential HIV testing and counseling services at a LHD operated or contracted site.
e. Alliance Member Services is available to assist Members requesting access to HIV testing and counseling services by informing them of their options described above and/or referring them to LHD operated or contracted sites.
f. PCPs and specialists caring for Members who are children must offer HIV counseling to parents or legal guardians and education, counseling and testing where appropriate to infants, children and adolescents in the following categories:
    1). Infants and children of HIV seropositive mothers.
    2). Infants and children of mothers at high risk for HIV infection with unknown HIV serologic status including:
        i). Children born with a positive drug screen;
        ii). Children born to mothers who admit to present or past use of illicit drugs;
        iii). Children born with symptoms of drug withdrawal;
        iv). Children born to mothers who have arrests for drug-related offenses or prostitution;
        v). Children born to mothers with any male partners at high risk for HIV; and

vi). Any abandoned newborn infants.

3). Sexually abused children and adolescents.

4). Children receiving blood transfusion/blood products between 1977-1985 or symptomatic children receiving transfusions since 1985.

5). Adolescents who engage in high risk behaviors including unprotected sexual activity, illicit drug use, or who have had STDs.

6). Other children deemed at high risk by a practitioner.

g. State Program Members that are under the age of 21 years who are confirmed HIV positive must be referred to the CCS Program.

2. HIV Testing, Counseling and Follow-up for Prenatal Women

a. Alliance network practitioners who provide women's health care services must comply with current law (California Health and Safety Code, Section 125107) that requires the health care professional primarily responsible for providing prenatal care to a pregnant Member to offer HIV information and counseling to every pregnant Member, including, but not limited to:

1). Mode of transmission

2). Risk reduction and behavior modification including methods to reduce the risk of perinatal transmission.

3). Referral to other HIV prevention and psychosocial services

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

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

1). The purpose of the test.

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

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

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

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

b. Out-of-network practitioners must submit claims to the Alliance Claims Department on HCFA 1500 billing forms using appropriate CPT and ICD-10 codes.

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

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

e. All documentation in Member's charts and release of information regarding HIV tests must conform to all provisions of California Health and Safety Code Division 105, Part 4, including Sections 120975, 120980, 120985, and 121010, 199.25, and Insurance Code Section 791.06. Confidentiality guidelines are set below:

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

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

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

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

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

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

5. Reporting

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

I. Abortion Services

1. Coverage

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

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

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

2. Accessing Abortion Services

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

b. Will inform members when they enroll that some hospitals, clinics, and other Providers in their Network may refuse to provide abortion services. In such case, the Alliance must help the member find another provider for the needed services.

c. Healthy Families and Non-State Program Members may self-refer without prior authorization, to a qualified practitioner within the Alliance Network.

d. Out-Of-Network Reimbursement for Abortion Services.

1). If a Member chooses to see an Out-Of-Network practitioner for abortion services, the reimbursement rate will not be lower, and is not required to be higher, than the Medi-Cal fee-for-service rate unless the Out-Of-Network practitioner and the Alliance mutually agree to a different reimbursement

rate.

3. Consent to Abortion Services
   a. Minor consent – refer to the MediCal Minor Consent Program and CMP-015 Minor Consent to Medical Care
4. Prohibition Against Interfering with Abortion Services

The Reproductive Privacy Act (Health and Safety Code Section 123460, et seq.) provides that California, and plans as contractors, may not deny or interfere with a women's right to choose or obtain an abortion prior to viability of the fetus or when an abortion is necessary to protect the life or health of the pregnant individual.

F. Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS / ACRONYMS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-023 Communicable Disease Reporting and Services
CMP-015 Minor Consent to Medical Care
CMP- 019 Delegation Oversight

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

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

REFERENCES

1. DHCS Contract Exhibit A, Attachment 9, Provision 9
2. Title 22, Section 51305.(1), (2), (3), (4)
3. California Family Code Sections 6925-6928
3. All Plan Letter 24-003
4. Reproductive Privacy Act
5. The Medi-Cal Provider Manual for the Minor Consent Program
6. Health and Safety Code section 123420
7. Title 22, California Code of Regulations (CCR), Section 51327
8. Senate Bill 245 (Chapter 11, Statutes of 2022)
9. Health Care Coverage: Abortion Services: cost sharing, SB 245, (Chapter 11, Statutes of

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 and Administrative Oversight Committee.

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POLICY AND PROCEDURE

Policy Number	UM-032
Policy Name	Therapeutic Enteral Formulas
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	1/1/2008
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/16/2024
Compliance Committee Approval Date	3/19/2024

POLICY STATEMENT

Enteral nutrition products may be covered upon authorization when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food *(California Code of Regulations* [CCR], Title 22, Section 51313.3).

The Department of Health Care Services' (DHCS) Medi-Cal pharmacy benefit limits the enteral nutrition product benefit to those products administered through a gastric, nasogastric, or jejunostomy feeding tube, for adults 22 years of age or older, with the exception of products consumer orally for inborn error of metabolism, and products consumed orally for intestinal malabsorption diagnoses. Beneficiaries 21 years of age and younger are exempt from the enteral nutrition product benefit tube feeding limitation.

Enteral nutrition products are reimbursable through Medi-Cal Rx as a pharmacy-billed item for products administered orally or through a tube. Parenteral services will continue under the medical benefit and be managed by the Alliance or Delegates. Services provided under MediCal Rx are described in the *Enteral Nutrition Products* sections of the Medi-Cal Allied Health Provider Manual.

Unless otherwise indicated, the majority of activities will be applicable to Medi-Cal only.

The Alliance will seek opportunities to work collaboratively with local county and community agencies through the Memorandum of Understanding (MOU) process to evaluate and meet the needs of these high-risk health plan members.

PROCEDURE

A. Authorization of Therapeutic Enteral Formulas

1. A prescription by a licensed provider is required for medical authorization of enteral nutrition products.
2. Authorization procedures and review for approval of therapeutic enteral formulas will be supervised by qualified healthcare professionals and denials will be reviewed by a qualified physician.
3. The enteral nutrition product requested on an authorization must be on the *List of Enteral Nutrition Products as defined by the Department of Health Services (DHCS)* and the member must meet the medical criteria for the specific product category and, if applicable, product-specific criteria.
    a. Prior Authorization requests for Enteral Nutrition Formula will be made to DHCS utilizing the DHCS 6505 Medi-Cal Rx Enteral Nutrition Prior Authorization Request Form.
    b. Requests for Enteral Nutrition Supplies including syringes, pumps, tubing, etc. will be made directly to AAH using the AAH Prior Authorization Request Form.
    c. For Group Care (IHSS) Line of Business the Alliance will provide all enterenal nutrition formula and enteral nutrition supplies.
4. Determining medical necessity of enteral nutrition products for medical conditions requires a thorough history, physician examination, nutrition assessment, laboratory testing, feeding observation, when applicable, and evaluation of a member's behavior and home environment.
5. Decisions and appeals regarding therapeutic enteral formula will be performed in a timely manner by Medi-Cal Rx.
6. Services are based on the sensitivity of medical conditions and rendered as*:*
    a. Expedited requests: within 72 hours for services if a provider or a plan determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
    b. Non-emergency requests: within five (5) working days when proposed treatment meets objective medical criteria, and is not contraindicated.
7. Verbal or written notification will be provided to any provider requesting a service by prior authorization that is denied, approved, or modified in an amount, duration or scope that is less than that requested by the provider by Medi-Cal Rx.

8. Members will be notified in writing about denied, deferred, or modified services by Medi-Cal Rx.

9. Both providers and members will be notified about the appeals procedure by Medi-Cal Rx.

B. Informing Providers and Members

1. The Alliance will use the Provider Manual and Provider Newsletters to inform providers about:
   a. Prescription and authorization procedures for provision of therapeutic enteral formulas
   b. Timeliness standards
   c. Requirements for periodic physical assessment and follow-up evaluation
   d. Local referral resources
   e. Formulary list of approved therapeutic formulas, and processes for approval of newly marketed therapeutic enteral formulas.
2. The Alliance will inform members about the processes and procedures for provision of medically necessary therapeutic enteral formulas via:
   a. Member EOC
   b. Member Newsletters

C. Parenteral Nutrition requests will follow the prior authorization process outlined in UM-057 Authorization Service Requests

D. 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.*

DEFINITIONS

Therapeutic "medical" food is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation (21 U.S.C. 360ee(b)(3)).
Parenteral Nutrition are defined as solutions, suspensions, emulsions for injection or infusion, powders for injection or infusion, gels for injection and implants. They are sterile preparations intended to be administrated directly into the systemic circulation.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
UM-057 Authorization Service Requests

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

10/28/2009, 7/20/2012, 9/6/2012, 10/2/2012, 4/21/2014, 6/25/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 11/23/2021, 3/19/2024

REFERENCES

Medical Services Workflow- Therapeutic Formula Referrals

MMCD Policy Letter 14-003 Enteral Nutrition Products
Medi-Cal Provider Manual - Allied Health, March 2014, Enteral Nutrition Products:

- An Overview
- Elemental and Semi-Elemental
- Metabolic
- Specialized
- Specialty Infant
- Standard

Title 22 §51313.3
Welfare & Institutions Code § 14132.86, 14105.8, 14105.395 Title 42 CFR § 431.63(c)
DHCS Policy – Enteral Nutrition Products, December 2020
DHCS List of Enteral Nutrition Products
DHCS 6505 Medi-Cal Rx Enteral Nutrition Prior Authorization Request Form

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 and Compliance Committee annually.

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POLICY AND PROCEDURE

Policy Number	UM-036
Policy Name	Continuity of Care for Terminated and Non- Participating Providers
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	1/1/2008
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	7/17/2024

Overview

The Alliance provides for the completion and continuity of covered services by a terminated or out-of-network/non-participating provider (NPP) of any type at the member's request in accordance with Health and Safety Code Section 1373.96, including medical and mental health service providers.

Policy Statement

A. Current and Newly Enrolled Group Care and Medi-Cal Members

1. Upon their request, current Alliance Members or newly enrolled Members with specified conditions may continue to obtain an Active Course of Treatment and health care services from a terminated or non-contracted provider for a specific condition and time frame as noted below:

    a. **An acute condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

    b. **Serious chronic condition** is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of active treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation

with the Member and the terminated provider or non-contracting provider, consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.

c. **Pregnancy** is the three trimesters of pregnancy and the immediate postpartum period. Services shall be covered for the duration of the pregnancy and the immediate postpartum period of 12 months. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition must not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

d. **Terminal illness** is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services is provided for the duration of the terminal illness which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

e. **Newborn childcare** is the care of a newborn child between birth and age thirty-six (36) months. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.

f. **Performance of a surgery or other procedure** is a medical procedure that is authorized by the Alliance, if a current Member, or by a previous plan, if a new Member, as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the effective date of coverage for a newly enrolled Member, or within 180 days of the termination of the provider for a current Member.

g. **Pediatric Palliative Care** is a patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering for children. Members currently enrolled in the Alliance or transitioning from Medi-Cal FFS, the Alliance will allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network provider. The Alliance will not provide continuity of care for services that were excluded due to the PPC Waiver Program and that are not also covered by Medi-Cal under EPSDT per DHCS requirements.

2. The terminated or NPP must agree to terms and conditions and rates consistent with those used by the Alliance or provider group in the same or similar geographic area.

    a. If provider refuses rates or terms, The Alliance will make every effort to transition member to an appropriately qualified in-network provider.

    b. If a qualified in-network provider is not available, The Alliance will continue to negotiate rates or locate another qualified provider to care for member.

3. This policy is not applicable for current Members if the provider was terminated for medical disciplinary cause, fraud, abuse of the Medi-Cal program or any patient, convicted of a felony or other criminal activity, suspended from the federal Medicare or

Medicaid programs for any reason, lost or surrendered a license certificate or approval to provide health care or newly covered enrollees with individual coverage.

B. On January 1, 2024, Alameda County transitioned to a Single Plan Model county, and Medi-Cal recipients transitioned from a previous Medi-Cal Managed Care Plan (MCP) to Alameda Alliance for Health (AAH) as their MCP. During the transition, AAH will adhere to the requirements of APL 23-018 Managed Care Health Plan Transition Policy Guide (Policy Guide), which establishes the 2024 Managed Care Plan Transition Policy Guide as the DHCS authority, along with the applicable Contract, and any incorporated APLs or guidance documents incorporated into the Policy Guide by reference, regarding the 2024 MCP transition.

    a. The AAH policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

    b. Particular attention and resources will be focused on members in Special Populations:
        - Adults and children with authorizations to receive Enhanced Care Management (ECM) services
        - Adults and children with authorizations to receive Community Supports (CS).
        - Adults and children receiving Complex Care Management (CCM)
        - Enrolled in 1915(c) waiver programs
        - Receiving in-home supportive services (IHSS)
        - Children and youth enrolled in California Children's Services (CCS)
        - Children and youth receiving foster care, and former foster youth through age 25
        - In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
        - Taking immunosuppressive medications, immunomodulators, and biologics
        - Receiving treatment for end-stage renal disease (ESRD)
        - Living with an intellectual or developmental disability (I/DD) diagnosis
        - Living with a dementia diagnosis
        - In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
        - Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
        - Receiving specialty mental health services (adults, youth, and children)
        - Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
        - Receiving hospice care
        - Receiving home health
        - Residing in Skilled Nursing Facilities (SNF)
        - Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
        - Receiving hospital inpatient care
        - Post-discharge from inpatient hospital, SNF, or sub-acute facility on or

after December 1, 2023
- Newly prescribed DME (within 30 days of January 1, 2024)
- Members receiving Community-Based Adult Services (CBAS)

c. See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

C. The Alliance will maintain standards of communication and processes for the appropriate sharing of information (e.g., adequate, timely feedback and consultation) and coordination of care between and among medical and mental health providers, general and specialty practitioners, and institutions, referring and consulting providers.

D. For Group Care Mental Health Services (employer-sponsored group health), The Alliance:

1. Maintains a process for block transfers of enrollees from a terminated provider group to a new provider group or hospital.

2. Maintains a process to facilitate the CoC for a new enrollee who has been receiving services from a NPP mental health provider for an acute, serious, or chronic mental health condition when an employer changed health plans. This includes a reasonable transition period to continue the course of treatment with the NPP prior to transferring to a participating provider and includes the provision of mental health services on a timely, appropriate, medically necessary basis from the NPP. The process provides that the length of time of the transition period take into account on a cases-by-case basis, the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. The process ensures that reasonable considerations are given to the potential clinical effect of a change of provider on the Member's treatment of the condition. The process describes the process to review a Member's request to continue the course of treatment with the NPP mental health provider.

3. NPP mental health are not required to be contracted with The Alliance or its delegate but will require a written contract as a condition of the right to treatment an Alliance Member defining the same contractual terms and conditions that are imposed upon the participating providers, including location within the service area, reimbursement methodologies and rates of payment. This will include a quality review assessment of the NPP mental health provider.

    a. When The Alliance determines that a member's health care treatment should temporarily continue with an existing provider or NPP mental health provider, the Alliance shall not be liable for actions resulting solely from the negligence, malpractice, or the tortious or wrongful acts arising out of the provisions of service by the existing provider or a NPP mental health provider.

4. Facilitates the completion of covered services pursuant to H&S Section 1373.96.

5. Provides Evidence of Coverage for Member communication describing the policy and informing Members of their rights to the completion of covered services.

6. Maintains processes to ensure that reasonable consideration is given to the potential clinical effects on a Member's treatment caused by a change in provider.

E. In the event a provider is terminated, all assigned Members are notified in writing (Attachment A) of the termination and their right to continue care 60 days prior to the termination effective date and are informed of the procedures for selecting another provider.

F. The Alliance maintains mechanisms to facilitate transition of care (including enrollee

notification when:

1. An individual in a course of treatment enrollees in the Plan and
2. When a medical group or provider is terminated from the network.

G. The Alliance reserves the right to make final decisions regarding continuity of care.

1. An Alliance Medical Director makes such decisions with consideration given to the potential effects on the Member's clinical condition and whether they are receiving an active course of treatment for acute or chronic conditions.

H. Communication to Members:

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

I. Any newly enrolled Member request COC or may obtain a copy of this policy upon written request to Alliance or by calling Member Services.

I. The Alliance is not required to cover services that are not otherwise covered by the Plan.

J. The Alliance notifies members of alternative resources in situations when members are receiving approved and medically necessary services but whose benefit coverage end or has ended.

K. The Alliance will manage the process of care transitions, identify problems that could cause transitions, facilitate safe transitions and, where possible, prevent or minimize unplanned transitions.

L. The Alliance Medical Services, Case and Disease Management Departments and their supporting units as well as the Member Services Department will collaborate in the management of care transition processes. This process includes review to determine whether the member's current treatment/care is transferable to another provider without compromising quality of care.

M. The Alliance utilizes evidenced based criteria, the application of medical necessity and reasonable consideration to the potential clinical effects on the Members' treatment caused by a change in Provider in consideration of a continuation of care.

N. The Alliance may delegate this responsibility to a provider group and ensures that the requirements are met.

O. The Alliance reserves the right to make all final decisions regarding continuity of care for Alliance Members.

PROCEDURE

A. All newly enrolled Members receive the Alliance's notice of the continuity of care policy in the Evidence of Coverage and Disclosure Form that is sent at time of enrollment.

1. Former Covered California members transitioning into Medi-Cal, Seniors and Persons with Disabilities with active Treatment Authorization Requests, and individuals identified on the Exemption Transition Data Report will receive additional outreach regarding continuity of care from the Member Services Department.

B. CoC requests are managed using the same mechanisms and processes for both medical and

mental health services.

C. Requests from newly enrolled Members to continue their care with a NPP of any type will typically originate with the Outpatient Utilization Management Department.

1. Any such request is documented by Alliance Utilization Management Department with subsequent referral to an Alliance Medical Director, if necessary.
2. The Alliance UM Department Standards to begin review of request for CoC within:
    a. Routine request within five (5) business days.
    b. Urgent matters are reviewed and responded to within 72 hours.
3. Each continuity of care request must be completed within the following timeline:
    a. Thirty calendar days from the date The Alliance received the request;
    b. Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
    c. Three calendar days if there is risk of harm to the member.
    d. Note: timeframes may be extended due NPP contracting phase; contracting should be completed within the standard timeframe but not to exceed 30 calendar days from the date of the receipt of the request.
4. Alliance Medical Services will evaluate the request based on the regulatory requirements outlined in Health and Safety Code Section 1373.96.
5. Alliance Medical Services will notify Alliance Contracts Management via a Health Suite Service Request of all approved authorizations.
6. UM Coordinators are responsible for daily monitoring Health Suite Service Request email distribution inbox.
7. UM Coordinators will review each request for:
    a. Eligibility
    b. Confirmation of Provider network status
    c. Obtaining medical records, if necessary
    d. Assignment to UM Nurse for review

D. UM Nurse Specialist/ Reviewer is responsible for reviewing each Member or NPP request for CoC.

1. Requests are reviewed based on the member conditions as noted in Section 2.1.

E. UM Nurse Specialist or designee will contact the Provider to confirm the request and obtain any additional information as needed.

F. The UM Nurse Specialist/ Reviewer is responsible for ensuring communication among the providers between all levels of care (e.g. acute inpatient care, sub-acute admissions, outpatient care/treatment) will contact the appropriate The Alliance delegate's UM Staff or to facilitate the timely exchange for co-management. UM Nurse Specialist/ Reviewer or designee will contact the requested NPP to confirm agreement to of existing active treatment plan or criteria met and NPP agreement to continue services to Member.

1. Once information is obtained, the request is forwarded to The Alliance Medical Director to confirm CoC exists and meets criteria.
    a. If criteria met, the UM Coordinator will notify the Alliance Contracts Management team via Health Suite SR process with all applicable information to begin rate negotiations.
    b. The UM coordinator will generate an approval level for Continuity of Care as outlined by regulation to all applicable parties.
    c. If criteria is not met, the Alliance Medical Director will document the reason for the denial of the determination in the UM Clinical Information System.
        - The UM Coordinator will create communication to the member and provider(s) as scribed by the Medical Director.UM Coordinator will contact the assigned PCP and Provider Group to ensure communication of the denial and coordination of necessary medical treatment.

G. For Mental Health Services
1. The Behavioral Health (BH) department staff are responsible for ensuring the review of request for CoC with a NPP mental health provider.
2. For services that require co-management, the BH staff are responsible for ensuring communication among the providers between all levels of care (e.g., inpatient care, partial hospitalization, outpatient care, day, and residential treatment) and will facilitate the timely exchange of information for co-management.
3. When needed, the BH staff will ensure communication between and among BH and medical providers to ensure appropriate evaluation, screening, diagnosis, and treatment of serious mental health illness, serious emotional disturbances, and autism conditions.

H. Rates of Payment and Agreement of Terms
1. Through a Letter of Agreement, Alliance Contracts Management will offer the non-contracting providers who may continue services:
    a. The rates and methods of payment similar to those used by the Alliance or the provider group for currently contracted providers providing similar services or the Medi-Cal fee for service rate, whichever is higher.
    b. The rates offered will be for providers who are not capitated and who are practicing in the same similar geographic areas as the non-contracting provider.
    c. The NPP will be subject to the same contractual terms and conditions as contracting providers.
2. If the NPP agrees to the rate, terms and conditions, Contract Management notifies Medical Services and Medical Services sends to the member and the provider a notice authorizing the continued services.
3. If the NPP does not agree to the rates, or terms and conditions or fails to respond to the Alliance within 30 calendar days of the request for continuity of care, the following will occur:
    a. Contract Management will notify Alliance Medical Services to reverse the authorization.
    b. Alliance Medical Services will send the member and the provider a notice that continuity of care services have been denied because the Alliance and the non-

contracted provider were unable to reach agreement.

c. Medical Services will coordinate with Member Services to identify an alternative provider for the member to continue receiving care with a contracted provider.

I. UM Nurse Specialist or designee will contact the requested Provider to confirm agreement to of existing active treatment plan or criteria met and NPP agreement to continue services to Member.

1. Once information obtained,

a. When rates approved, the UM Coordinator will notify the Member and NPP in writing as well as the assigned PCP and assigned Provider Group to ensure necessary documentation as well as verification of primary care continuing as the responsibility of the Provider Group.

b. If rates not agreed upon,

1). The Alliance Medical Director will document the reason for the denial of the determination in the UM Clinical Information System.

2). UM Coordinator is responsible for management of UM referral determination documentation and written communication to the Member and NPP under the direction of the UM Medical Director.

i). UM Coordinator will contact the assigned PCP and Provider Group to ensure communication of the denial and coordination of necessary medical treatment.

J. In situations when members are receiving approved and medically necessary services but whose benefit coverage ends, the Alliance notifies members of the existence of alternative resources. (Attachment B).

K. Managing Transitions/Members in hospital or sub-acute setting at the time of the termination

1. Identification of planned transitions from members' usual setting of care to the hospital and transitions from the hospital to the next setting.

a. Planned/Unplanned Transitions. All elective inpatient admissions require prior authorization by the Alliance or a delegated Provider Group.

1) For terminating providers/ Contracted Facilities, The Alliance/Provider Groups will obtain a list of all maintain paper and electronic files on all authorization requests to identify Members who may be impacted by the termination.

b. For newly enrolled Members who are hospitalized at the time of the assignment to The Alliance and who meet the criteria noted in Section 2.1, the UM Nurse Specialist will review each case with the UM Medical Director and follow the stated procedures in this section.

L. Honoring Existing and Active Prior Treatment Authorizations (PAs) and Treatment Authorization Requests (TARs)

1. For terminated providers, the UM Department will collaborate with Provider Relations to

ensure any associated Provider Groups are notified of these specific members with an existing and active PA or TAR that the Alliance or the delegate will honor the PA or TAR for ninety (90) days or until an appropriate assessment is completed by a contracted provider.

M. Block Transfers – Please refer to the Alliance's Block Transfer P&P for the Alliance's process for handling the termination of a Provider contract that could involve the block (entire) transfer of Members.

N. Delegated Providers

1. The Alliance will ensure compliance with the regulatory requirements for continuity of care by delegated groups and oversee the compliance through the delegation oversight process; i.e., quarterly reporting, annual on-site review, investigation of complaints, and review of denials.
2. Any written, printed, or electronic notification to the Member regarding a contract termination or block transfer (transfer of all of a provider's Members) must include the following language: "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact The Alliance's Member Service Department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov".

O. Continuity of Care Reporting Requirements:

1. The Analytics, IT and Medical Services Departments will work together in order to ensure the Alliance submits all required quarterly continuity of care reports.
2. On a monthly basis, the UM Manager or designee will review CoC data and reporting requirements to ensure data is available for internal and regulatory reporting.
3. On a quarterly basis, the UM Manager and Director of Health Services will review the CoC data and provide a summary report with identification of opportunities to improve the UM experience to the UM Committee.

4. On a monthly basis, the IT department will provide data to the Compliance Department for regulatory reporting.

DEFINITIONS

1. **Active Treatment** - An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol.
2. **Individual Provider** – A person who is licentiate, as defined in Section 805 of Business and Professional Code or a person licensed under Chapter 2 of Division 2 of the Business and Professions Code.
3. **Nonparticipating Mental Health Provider –** A psychiatrist, licensed psychologist, licensed marriage and family therapist, licensed social worker, or licensed professional clinical counselor who does not contract with the specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.
4. **Nonparticipating Provider** - A provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.
5. **Non-Contracted Provider** – Any provider that is not contracted with the Alliance.
6. **Planned Transitions** include elective surgery or a decision to enter a long-term care facility.
7. **Post-Partum Period** – Commonly defined as the six weeks after childbirth.
8. **Provider** – any professional person, organization, health facility, or other person or institution licensed by the State to deliver or furnish health services.
9. **Provider Group –** A Medical Group, Independent Practice Association, or any other similar organization.
10. **Unplanned Transitions** include any non-elective admission to an acute or long-term care inpatient facility, or any emergency room visit.
11. **Terminating Provider** – any Provider whose contract with the Alliance is in the process of termination, regardless of which entity initiated the termination process.
12. **Transition** - Movement of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery.

AFFECTED DEPARTMENTS/PARTIES

Member Services
Provider Relations
Contract Management
Health Analytics
Medical Services
Behavioral Health

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. PRV-002 Block Transfers
2. BH-002 Behavioral Health Services
3. UM-001 UM Program
4. UM-058 CoC for New Enrollees with MER
5. UM-059 CoC for Enrollees Transitioning into Medi-Cal Managed Care

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REVISION HISTORY

10/28/2009, 4/1/2011, 1/25/2012, 9/7/2012, 12/5/2012, 1/9/2013, 1/30/2013, 12/26/2013, 4/25/2014, 7/14/2014, 2/11/2015, 01/10/2016, 04/12/2018, 3/21/2019, 3/19/2020, 5/21/2020, 3/18/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 12/19/2023, 7/17/2024

REFERENCES

- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- APL 21-003 Medi-Cal Network Provider and Subcontractor Terminations
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- Continuity of Care Workflow for Member Services Department
- Continuity of Care Authorization Workflow for Medical Services Department
- Health & Safety Code Sections 1371.8, 1373.65, 1373.95 & 1373.96
- Letter of Agreement Process in Policy and Procedure NTM-CON-002
- Medi-Cal and Group Care Evidence of Coverage
- NCQA Standards

MONITORING

The Compliance and Utilization Department are responsible for initial and annual delegation oversight of the provision of continuity of care services.

At least annually, the UM Department will review this policy annually for compliance with regulatory and contractual requirements.

At least annually, the UM Department will review a statistically significant file review selection to evidence compliance with the CoC processes.

Outcomes of the annual delegation oversight and file review are presented to the Quality Improvement Health Equity Committee annually.

I.

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POLICY AND PROCEDURE

Policy Number	UM-045
Policy Name	Communication Services - UM
Department Name	Health Care Services
Department Owner	Medical Director
Lines of Business	MCAL, IHSS
Effective Date	10/6/2011
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/16/2024
Compliance Committee Approval Date	3/19/2024

POLICY STATEMENT

All Alameda Alliance for Health (AAH) members and providers can access UM staff when seeking information about the authorization/referral process and/or the UM process (such as criteria used and ability to speak with the reviewer). AAH uses multiple means of communication with members about their rights related to UM, benefits, and care.

PROCEDURE

AAH provides the following communication services for members and providers related to the utilization management (UM) reviews and processes:

1. AAH provides the ability to speak with a UM staff member at least 8 hours a day during normal business hours for inbound calls regarding UM issues. This is provided by utilization review staff that is available by phone during normal business hours of 8 am to 5 pm Pacific Time. AAH also offers walk in services to members and providers at its office.

2. After normal business hours inbound calls are received by voice mail and returned the next business day by UM staff. UM staff converts the phones to voice mail at the end of each day and then receive and return the voicemails on the next business day. AAH also provides 24-hour fax capabilities and email for additional inbound communication after normal business hours regarding UM issues. UM staff receives faxes and emails and processes them in accordance with review turnaround times.

3. Staff are available 24 hours, 7 days a week for providers seeking authorizations for

post-ER stabilization care. Calls after hours are triaged by AAH clinical staff. Staff are also available on the weekends and holidays during the daytime for assistance with discharge planning and transfers to step down facilities.

4. UM staff sends outbound communications in the form of outbound calls, letters confirming UM decisions, emails, and faxes. The communications comply with the requirements for approval and denial letters in terms of content and timing. UM staff use templates to ensure consistency and review customized communications with the Supervisor prior to sending.

5. When answering the phone all UM staff will identify themselves by their name, title and that the caller has reached AAH when initiating or returning calls regarding UM issues. AAH confirms compliance with this through routine monitoring of phone calls performed by the UM Supervisor. Staff that do not comply are coached on effective communication techniques including providing identification.

6. AAH provides telephone numbers to members and providers that they can use to access the UM department and staff. Providers access the UM department directly through 1(510) 747-4540 and members call Member Services at 1(510)747-4567 or at 1(877) 371-2222. Member Services then warm transfers the member to the UM department during normal business hours. This toll-free number is supplied in newsletters, on the website and in enrollment materials to facilitate access to UM staff. AAH also has a toll-free number to member services and member services staff can warm transfer members and providers to the UM department.

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

8. Specific AAH UM staff may be onsite at AAH and can communicate directly with members and providers regarding their questions about the UM process. AAH provides access to UM staff 9 hours a day both directly and through coordination with other areas such as provider services or member services that may refer a caller in who has questions about the UM process. The presence of onsite staff will follow any State of California declared Public Health Emergency (PHE) requirements. If staff are not onsite due to the PHE, they are available by phone or fax to assist providers and members.

9. AAH offers TDD/TTY and California Relay services for deaf, hard of hearing or speech-impaired members. All UM staff members are trained in how to assist members in accessing these services or UM staff may access these services themselves directly to assist a member. The information regarding the services is listed on the AAH website, in newsletters to members and providers and in enrollment and orientation materials.

10. AAH offers alternative formats for members with visual impairments, such as auxiliary aids and services, giving primary consideration to the member's request of a particular auxiliary aid or service. AAH will offer the alternative formats aids and services to the member and/or a family member, friend, or associate of a member if required by the ADA, including if said individual is identified as the member's authorized representative (AR), or is someone with whom it is appropriate for AAH to communicate (e.g., a disabled spouse of a member). AAH will accommodate the communication needs of all qualified members with disabilities, including ARs, and be prepared to facilitate alternative format requests for Braille, audio format, large print (no less than 20 point Arial font), and accessible electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate. AAH will inform a member who contacts AAH regarding an electronic alternative format, that unless the member

requests a password protected format, the member will receive notices and information in an electronic format that is not password protected.

a. The member or AR may contact AAH Member Services, UM or the Case Management department if they wish to use an alternative format. Member Services/UM warm transfers the member to the Case Management department during normal business hours. The Case Management department will assist the member to obtain the alternative format aid or service.

b. AAH will calculate the deadline for a member with visual impairment or other disability requiring provision of written materials in alternative formats, to take action from the date of adequate notice, including all deadlines for appeals and aid paid pending.

11. AAH recognizes the diverse cultural and linguistic needs of our members. AAH hires staff in UM and other areas that are bi-lingual, and a list of those staff and their language abilities is kept in a resource guide for UM staff. If a staff member is not available to assist in translating or speaking with the member in their language, AAH has a contracted interpreter service. UM staff are trained in how to access this service.

12. Information regarding how to access UM staff to discuss UM issues is provided in provider denial notifications, the provider manual, and member denial of service notifications. There is a direct telephone number listed for any denial, delay, or modification of a requested service for the healthcare professional that is responsible for the UM decision.

13. The Member Handbook/Evidence of Coverage is always available to members on the AAH website and will be sent to members upon request. The Handbook describes communication methods available to members regarding all aspects of their AAH membership, such as what services do or do not require prior authorization, how to get all types of care in and out of network, how to access emergency services, second opinions, and sensitive services, the availability of care coordination to assist members to obtain care, and how to access all rights, benefits, and resources available to members.

DEFINITIONS

Accessibility – The extent to which a patient can obtain available services when they are needed. 'Services' refers to both telephone access and ease of scheduling an appointment, if applicable.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. UM-001 UM Authorization Process
2. BH-002 Behavioral Health Services

REVISION HISTORY

8/2/2012, 4/21/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 3/19/2024

REFERENCES

- NCQA 2014 Health Plan Standards, UM Standard 3.A.
- Alameda Alliance for Health Contract with DHCS, Exhibit A, Attachment 13 Member Services, 1. A. 1 (a)
- DHCS APL 22-002: Alternative Format Selection for Members with Visual Impairments.

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 and Compliance Committee annually.

POLICY AND PROCEDURE

Policy Number	UM-046
Policy Name	Use of Board Certified Consultants
Department Name	Utilization Management Division
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	08/21/2024
Administrative Oversight Committee Approval Date	9/18/2024

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 Board Certified consultants to assist in making medical necessity and appropriateness of care decisions and meet the review needs of the plan. The use of Board Certified consultants is outlined in Section One (1) below.

The Alliance Chief Medical Officer (CMO) maintains a current list of Board Certified consultants to assist in making medical necessity and appropriateness of care decisions and meet the review needs of the plan.

The list of Board Certified consultants is reviewed 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 Certified consultants will provide an independent medical review with medical necessity recommendations based on peer reviewed published journals, national organization guidelines, and expert opinion.
2. **High Complexity or Specialized Procedures and Services** – Board Certified Consultants should be used to review highly complex procedures. These procedures or services require the review of a professional in the same or similar specialty to the physician performing the procedure.
3. **Insufficient Levels of Certification** – Board Certified Consultants should be used when the physician performing the procedure or service is highly credentialed or board certified and internal review resources are not similarly credentialed or certified.
4. **Conflict of Interest** – Board Certified Consultants should be used if available internal reviewers have established personal or professional conflicts of interest.

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 Board Certified consultant review are submitted online via the AMR secure client portal.
    b. Appropriate Alliance staff receive training on how to contact AMR and use board certified consultant services.
2. The Alliance will take the following steps to ensure the consultant's appropriate involvement once it is determined that the use of a Board Certified consultant is necessary:
    a. Access the AMR web portal and submit a request for the Board Certified consultant review.
    b. Attach, fax or email necessary case information.
    c. Receive decision and supporting explanations within 24 hours of their receipt of initial case information.

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
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, **9/18/2024**

Red = substantive updates

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.

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POLICY AND PROCEDURE

Policy Number	UM-048
Policy Name	Triage & Screening Services
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, IHSS
Effective Date	3/31/2015
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	7/17/2024

POLICY STATEMENT

Alameda Alliance for Health ("Alliance") arranges for triage and screening services available by telephone to members 24 hours per day, 7 days per week. The plan ensures that the telephone triage or screening services are provided in a timely manner appropriate for the requesting member's condition.

Triage services are provided by the Alliance by the telephone medical advice services and the Alliance's primary care and mental health provider network. When the Alliance uses its primary care and mental health network to provide triage services it requires its providers to maintain a procedure for triaging or screening member telephone calls.

The plan has unlicensed staff who ask questions on behalf of a licensed staff person in order to help ascertain the condition of a member in order to refer the member to the adequate licensed staff. Though under no circumstances does the Alliance allow unlicensed staff to answer questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional.

PROCEDURE

Alameda Alliance for Health is contingent on its contracted provider network to provide triage services to its members. Primary care providers and mental health care providers must provide triage and screening services 24 hours a day, 7 days a week. The provider's wait time for triage services is required to not exceed thirty (30) minutes.

A. <u>Provider Triage and Screening Procedures</u>

The providers must maintain the following procedures for triage and screening member telephone calls:

1. Employment, during and after hours, of a telephone answering machine and/or an answering service and/or office staff.
2. Notice to caller regarding length of wait for a return call from the provider.
3. Notice to caller regarding how they may obtain urgent or emergency care including, if applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

B. Nurse Advice Line

For cases when the providers are unable to meet the time-elapsed standards, the Plan provides members the Plan's nurse advice line to call as an alternative triage and screening service arrangement. Providers who are unable to provide triage and screening services are required to inform members about the Alliance's nurse advice line information. The nurse advice line provides interpreter services in threshold languages that are identified by DHCS within the Alliance's Service Area, and by the Alliance through membership assessments. See *CLS-008 Member Assessment of Cultural and Linguistic Needs* for more details.

The Alliance uses a nurse line to handle any calls that cannot be answered within the thirty (30) minute threshold for its Medi-Cal and Group Care (IHSS) members. The phone number for the nurse line is included in the EOC and Alliance website. Members may access the nurse line by calling the customer service line, located on the membership card, and following the appropriate prompts.

The Alliance monitors the triage standards for the Nurse Advice Line to ensure that the line provides 24 hours per day, 7 days per week triage/screening services in a timely manner appropriate for the members' condition, and that the waiting time does not exceed 30 minutes. This is done by reviewing quarterly reports on Nurse Line processes, including timeliness of responding to calls.

For behavioral health care needs, AAH provides triage and screening services for members and providers. See policy BH-002 Behavioral Health Services and MBR-062 MS Referrals and Triage .

C. <u>Member Distribution</u>

The Alliance provides members with information about the availability of triage and screening services and how to obtain the services in its Evidence of Coverage (EOC). The Alliance's EOC is provided to members upon enrollment and annually thereafter. The Alliance's website also provides information on triage and screening services. The Providers are provided with the triage and screening requirements as a part of the orientation when contracted with the Alliance, and in the Provider Manual posted on the Alliance's website.

DEFINITIONS / ACRONYMS

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

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

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Member Services
Case Management
Behavioral Health

Quality Management
Provider Services
Compliance

RELATED POLICIES AND PROCEDURES

QI-107 Appointment Access and Availability Standards
QI-108 Access to Behavioral Health Services
QI-114 Monitoring Access and Availability Standards QI-115Access and Availability Committee
QI-116 Provider Appointment Availability Survey
QI-117 Member Satisfaction Survey
QI-118 Provider Satisfaction Survey
CLS-008 Member Assessment of Cultural and Linguistic Services
CLS-009 CLS Program – Contracted Providers
CLS-011 CLS Program- Compliance Monitoring
PRV-003 Provider Network Capacity Standards
BH-002 Behavioral Health Services
MBR-062 MS Referrals and Triage

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

01/10/2016, 12/15/2016, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 7/17/2024

REFERENCES

DHCS Contract Exhibit A, Attachment 9 Access and Availability
Title 28, CCR, §1300.67.2, Accessibility of Services
Title 28, CCR § 1300.67.2.2 Timely Access to Non-Emergency Health Care Services

MONITORING

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

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POLICY AND PROCEDURE

Policy Number	UM-051
Policy Name	Timeliness of UM Decision Making and Notification
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	11/10/2016
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

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

POLICY

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

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

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

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

B. Measurement of Timeliness

1. Counting days for Authorization Requests
    a. Day of receipt of request is counted as day zero.
    b. Day following day of receipt of request is counted as day one, etc.

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

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

D. Receiving Authorizations During Business Hours and After Business Hours

1. For requests received during normal business hours by UM phone line, fax, or portal the date/time received is logged as the same the telephone call, fax, or portal submission is received.

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

E. Alameda Alliance has a process for determining urgency (expedited request status)
1. When a pre-service request is marked as urgent (expedited) on the request form and the UM Clinical Reviewer questions the urgency, the UM Clinical Reviewer will forward the request to a Medical Director reviewer to determine whether the request is urgent (expedited) or routine, based on the presenting referral information.
    a. The Physician Reviewer is the only decision maker than can determine if a request needs to be deescalated from Urgent to Routine.

F. Concurrent Review
1. Care shall not be discontinued until the treating provider has been notified of the Plan's decision for denial and a care plan has been agreed upon by the treating provider which is appropriate for the medical needs of that patient.

PROCEDURE

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

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

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

3. Sends notifications to the Member and Provider about UM decisions according to the applicable current regulatory timeliness standards.

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

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

2. For requests received outside of normal business hours by 510-326-5271 line, the date of receipt is logged as the same day the telephone call is received.

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

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

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

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

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

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

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

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

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

E. MONITORING

1. The Utilization Management Department, on a routine basis, reviews the results from the monthly 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.

DEFINITIONS / ACRONYMS

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

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

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

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

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

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

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

H. **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.

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

AFFECTED DEPARTMENTS/PARTIES

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

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
RX-011 Decision and Notification Requirements
UM-001 UM Authorization Processes
UM-051 Attachment A: Alameda Alliance for Health UM Timeliness Standards for Medi-Cal and Group Care

REVISION HISTORY

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

REFERENCES

1. Attachment 13 – Member Services, Item 8 (A) through (E)
2. CA Health and Safety Code sections 1367.01(h)(1) through (5)
3. DHCS Two-Plan and GMC Boilerplate Contracts – Exhibit A, Attachment 5 – Utilization Management, Item 2 (A), (B), (F), (G), and (I); Item 3 (A) through (J)
4. MMCD Policy Letter 12-005 Enteral Feedings
5. Title 22 CCR Section 53855 (a) or any future amendments thereto.

POLICY AND PROCEDURE

Policy Number	UM-054
Policy Name	Notice of Action
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Lines of Business	MCAL, IHSS
Effective Date	10/12/2017
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

OVERVIEW

Alameda Alliance maintains processes and mechanisms to notify members and providers of Utilization Management (UM) determinations, (medical/surgical and behavioral health,) in a timely manner according to State and Federal regulations as well as NCQA standards.

A. POLICY

1. Members and requesting practitioners are provided with written notifications of UM decisions. These include notice of action (NOA) letters for denials, modifications, and deferrals/delays, which clearly and concisely document and communicate the reasons for the decision so that members and practitioners receive sufficient information in easily understandable language to be able to understand the decision and decide whether to appeal the decision.

    a. The NOA informs the member of an adverse benefit determination. An adverse benefit determination is defined to mean any of the following

actions taken by the Alliance as listed below:

i. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
ii. The reduction, suspension, or termination of a previously authorized service.
iii. The denial, in whole or in part, of payment for a service.
    a) The failure to provide services in a timely manner.
    b) The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
    c) For a resident of a rural area with only one health plan, the denial of the beneficiary's request to obtain services outside the network.
    d) The denial of a beneficiary's request to dispute financial liability.

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2. Notification documents
    a. Alameda Alliance utilizes the template NOAs approved by the California Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).
        i. The Member is informed of Alameda Alliance's decision by a written NOA. The NOA templates are approved by DHCS prior to use. Any changes to the templates are subject to DHCS review and approval prior to use. The NOA includes the "Your Rights under Managed Care" attachment explaining the member's right to the Alliance's appeal process, the State Fair Hearing, and the Independent Medical Review (IMR) process. The member must exhaust their appeal right with the Plan prior to requesting a State Fair Hearing or IMR case.
            1. Deemed exhaustion of appeals processes:
            2. If AAH fails to adhere to the State-established timeframes for notice and timing requirements in § 438.408, the member is deemed to have exhausted AAH's appeals process. The member may initiate a State fair hearing.
            3. If AAH fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements, the Member may request a State Fair Hearing.

        ii. Notice of Action (NOA) Requirements
            1. The written NOA shall include the following:
                a) A statement of the action the Alliance intends to take.
                b) A clear and concise explanation of the reasons for the decision. The specific reasons for the denial shall be in easily understandable language and include the clinical reasons for a decision regarding medical necessity.
                c) A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline.

d) The clinical reasons for the decision. Alliance shall explicitly state how the member's condition does not meet the criteria or guidelines.
    i. Medical Necessity Denials: Documentation within its system the reason for the denial and the specific evidenced based criterion used to make the denial.
    ii. Benefit Denials: For each benefit/non-medical necessity denial, Document within its system the reason for the denial, including the specific benefit provision, administrative procedure or regulatory limitation used to make the denial.
e) Documentation shall include this information in the denial notice sent to the member or the member's authorized representative.
f) For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the member in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively.
g) Statement included that the member can request copies of all documents and records relevant to the NOA free of charge, including the criteria and guidelines used. Any requests received by the Plan for the criteria or guidelines will include the specific procedures/conditions that were requested. The following disclosure notice will also be included with all copies of criteria requests "the materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefit covered under your contract."
h) The written NOA must have the current DHCS standardized "NOA Your Rights" Template, non-discrimination notice, and language taglines attachments enclosed. The written Your Rights Attachment includes the following:
    i. Member's or provider's right to request an internal Appeal to the Plan within 60 calendar days from the date on the NOA.
    ii. Member's right to request a state hearing only after filing an internal appeal with the Plan and receiving notice that the adverse benefit determination has been upheld.
    iii. Member's right to request a state hearing if the Plan fails to send a resolution notice in response to the Appeal within the required timeframe (Deemed Exhaustion).

1. Deemed exhaustion of appeals process: If AAH fails to adhere to the State-established timeframes for notice and timing requirements in § 438.408, the member is deemed to have exhausted AAH's appeals process. The member may initiate a State fair hearing

iv. If AAH fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements, the Member may request a State Fair Hearing.

v. Procedures for exercising the Member's rights to request an Appeal.

vi. Circumstances under which an expedited review is available and how to request it.

vii. Member's right to have benefits continue pending resolution of the Appeal and how to request a continuation of benefits in accordance with Title 42, CFR, Section 438.420.

1. The member's rights to Aid Paid Pending and instructions on how to timely file for an appeal (i.e. within 10 days of the NOA or before the effective date of the intended action) of a decision to terminate.

2. Translation
   a) NOA templates must be translated into the required threshold languages.
   b) NOA mailed to the member must be in the preferred threshold language using the translated template. The rationale for the adverse decision will also be translated into the preferred threshold language of the member.
   c) If member's preferred language is non-threshold, the member may request the letter to be translated into their preferred language. AAH will provide the full translation within 21 calendar days.

iii. Member Identifier in Approval and NOA letters:
1. Member social security numbers or member Medicare HIC numbers can never be used in UM approval or NOA letters. Use of these numbers constitutes a protected health information (PHI) breach.
2. If there is a legitimate business need to include the member Client Identification Number (CIN) on approval and NOA UM letters, then using the CIN number would be permissible.

iv. NOA Letters to Members and Providers Shall Also Include:
1. Member Appeal Rights according to the member's product line.
2. A reference to the evidence-based criteria, benefit provision as

described in the member's EOC, guideline, protocol.

3. Medi-Cal NOA letters shall also include a citation to the specific regulations or Alameda Alliance authorization procedures supporting the action on which the deferral, modification, denial, or termination decision is based.
4. Information about how the member can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the deferral, modification, denial, or termination decision is based.
5. Information on accessing interpretive in services in Threshold Languages and information regarding accessing Teletype/Tele Typewriter (TTY) service
6. Provider right to discuss the UM decision of denial, deferral, modification, or termination with the peer reviewer.
7. The NOA must include a phone number for the requesting practitioner to call the peer reviewer to discuss the decision.

b. Timeliness of notifications communication

   i. Refer to UM-051 Attachment A for Timeliness Standards for notifications to both provider and member

c. Oversight and monitoring of the notification process

   i. Refer to UM-051

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3. PROCEDURE

a. Production of NOA letters:

   i. Approvals

      1. Automatically generated by the system after approval entered.
      2. NOA approval letters mailed the next business day.
      3. Copy of the letter stored in system.

   ii. Denials

      1. Potential denials forwarded to UM Physician.
      2. Medical review of potential denials completed.
      3. Denial determination made and documented in system.
      4. Forwarded to UM coordinator.
      5. Coordinator produces NOA letter.
      6. NOA mailed the NOA the same day or next business day, and no later than the required two business days for routine authorization decisions, and within 72 hours for urgent authorizations.

b. Reports are generated from data from various sources:

   i. Authorization data systems
   ii. Claims and payments.
   iii. Encounter data
   iv. Medical records

c. The data is compared to available sources of comparable data and benchmarks:
    i. Internally developed performance measures
    ii. DHCS-established Minimum Performance Levels (MPLs) and High Performance Levels (HPLs).
    iii. National Medicaid HEDIS results for the 25th and 75th percentiles
    iv. Previous year's network performance
    v. CMS benchmarks when applicable
    vi. NCQA 75th percentile for industry standards
    vii. MCG criteria when applicable

d. The Behavioral Health department collects utilization management statistics, on at least a quarterly basis, to assess potential areas of under- or over-utilization of services.

e. Out of Network Behavioral Health Data is collected by AAH on at least a quarterly basis
    i. These data are reviewed by the Utilization Management Committee, to monitor the process for appropriate utilization of services.
    ii. Findings are reported at both the Utilization Management and the Quality Improvement Committee meetings because both quality and utilization components are included.
    iii. Detailed analysis may be conducted to determine the root cause of an identified trend.
    iv. Interventions are developed and approved by the Utilization Management and Quality Improvement Committees and carried out by departments.

f. Aggregation of all NOA data including Alameda Alliance, and delegates is done for performance monitoring of NOA compliance

g. Alameda Alliance generates monthly reports to monitor the network performance with the established measures.

    i. A statistical report is generated for outlier practitioners.

        1. A Practitioner Corrective Action Plan is developed as appropriate for outlier providers.

    ii. A statistical report of network adequacy is generated.

        1. A referral to Provider Services is made when network adequacy problems are identified.

h. Data from the monthly analysis is submitted as part of the UM Work Plan to the UM Subcommittee for discussion and recommendations for addressing outlier results.

i. The UM Subcommittee recommendations are reported to the Quality Improvement Health Equity Committee (QIHEC).

DEFINITIONS

Notice of Action (NOA) is defined as a formal letter from an MCP informing a member of an "adverse benefit determination."

Notice of Appeal Resolution (NAR) is a formal letter from an MCP informing a member of the outcome of an appeal of an adverse benefit determination.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES

UM-001 UM Authorization Processes
UM-051 Timeliness of UM Decisions
CMP-019 Delegation Oversight
BH-002 Behavioral Health Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/15/18, 11/21/19, 1/21/2021, 03/22/2022, 02/21/2023, 6/20/2023, 12/18/2024

REFERENCES

DHCS Contract, Exhibit A, Attachment 5 – Utilization Management
DHCS All Plan Letter 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights' Attachments—Superseded by APL 21-011
DHCS All Plan Letter 21-011 Grievance and Appeal Requirements, Notice, and "Your Rights" Templates

MONITORING

The Utilization Management Department, on a routine basis, reviews the results from the authorization audits conducted by the Alliance Compliance Department to ensure compliance with adverse benefit determinations and notice of action requirements.

This policy is reviewed annually to ensure compliance with regulatory and contractual requirements.

Policy Number	UM-055
Policy Name	Palliative Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Line(s) of Business	MCAL
Effective Date	1/01/2018
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

Pursuant to Senate Bill (SB) 1004 and Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020, and under Alameda Alliance for Health's (Alliance) contract relative to the provision of the Medi-Cal for Kids/ Teens (also known as Early Periodic Screening, Diagnostic and Treatment [EPSDT]) services, the Alliance authorizes palliative care services to its Medi-Cal members when those services are medically necessary. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the Alliance's contracts and does not affect a member's ability to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care.

Hospice care is a Medi-Cal benefit that serves terminally ill members. It consists of interventions that focus primarily on pain, stress and symptom management rather than a cure or the prolongation of life. To qualify for hospice care, a Medi-Cal member must have a life expectancy of six months or less. Further information regarding Medi-Cal hospice care is available in APL 13-014, titled "Hospice Services and Medi-Cal Managed Care," including any future iterations of this APL.

Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if they meet the hospice eligibility criteria. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care under the Section 1915(c) Home and Community Based Services waiver, known as the Pediatric Palliative Care waiver, or concurrent care under Section 2302 of the Patient Protection and Affordable Care Act (ACA). See APL 13-014, California Children's Services Numbered Letter 06-1011, and Managed Care Policy Letter #11-004.

Procedure

A. Eligibility Criteria

As outlined in APL 18-020, AAH adopts the DHCS' SB 1004 Palliative Care Policy for the minimum eligibility criteria for palliative care and will authorize palliative care services when medically necessary for members who meet the eligibility criteria.

Members of any age are eligible to receive palliative care services if they meet all the criteria outlined in Section A. below, and at least one of the five requirements outlined in Section B. Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in Section C below, consistent with the provision of Medi-Cal for Kids/ Teens (also known as Early Periodic Screening, Diagnostic and Treatment (EPSDT)) services.

B. General Eligibility Criteria:

1. Member must meet all criteria listed in section A, and at least one of the criteria listed in B-E**.**

a. The member is likely to, or has started to, use the hospital or emergency department to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
b. The member has an advanced illness, as defined in the disease specific eligibility section below, with appropriate documentation of continued decline in health status, and is not eligible for hospice (adult only; ≥ 21 years old) or declines hospice enrollment.
c. The member's death within a year would not be unexpected based on clinical status.
d. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
e. The member and, if applicable, family member/ member-designated support person, agrees to:
    - Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/ palliative care instead of first going to the emergency department; and
    - Participate in Advance Care Planning discussions

C. Disease Specific Eligibility Criteria

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
    a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; 10 and
    b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)
    a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or

b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
   a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
   b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone.
   a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
   b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
   c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

5. Advanced Dementia/ Alzheimer's Dementia: Must meet four (4) of five (5) criteria:
   a. Profound memory deficits
   b. Functional impairment (ADL dependencies)
   c. Minimal communication
   d. Decreased oral intake and/ or significant weight loss in last six (6) months.
   e. Malnutrition

D. Pediatric Palliative Care Eligibility Criteria

1. Must meet (a) and (b) listed below. Members under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.
   a. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
   b. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
      1. Conditions for which curative treatment is possible, but may fail (e.g., advanced, or progressive cancer or complex and severe congenital or acquired heart disease); or
      2. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
      3. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
      4. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

2. If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. AAH

has a process to identify members who are eligible for palliative care, including a provider referral process. AAH will periodically assess the member for changes in the member's condition or palliative care needs. AAH may discontinue palliative care that is no longer medically necessary or no longer reasonable.

3. For children who have an approved CCS-eligible condition, CCS remains responsible for medical treatment for the CCS-eligible condition, and AAH is responsible for the provision of palliative care services related to the CCS-eligible condition. AAH is also responsible for the provision of hospice services for pediatric members.

E. Palliative Care Services

1. When a member meets the minimum eligibility criteria for palliative care, AAH will authorize palliative care without regard to age. Palliative care includes, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

2. Advance Care Planning: Advance care planning for members enrolled in Medi-Cal palliative care under SB 1004 includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms. Please refer to the section on advance care planning in the Provider Manual for further details.

3. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:

    - Treatment plans, including palliative care and curative care.
    - Pain, symptoms, and medicine side effects
    - Emotional, stress, and social challenges
    - Spiritual concerns
    - Patient goals
    - Advance directives, including POLST forms.
    - Legally-recognized decision maker

4. Plan of Care: A plan of care is developed with the engagement of the member and/or the member's representative(s) in its design. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A member's plan of care includes all authorized palliative care, including but not limited to pain, and stress and symptom management and curative care. The plan of care must not include services already received through another Medi-Cal funded benefit program (e.g., CCS Program).

5. Palliative Care Team: The palliative care team is a group of individuals who work

together to meet the physical, medical, psychosocial, emotional, and spiritual needs of a member and of the member's family, and/or legally- recognized decision maker and are able to assist in identifying the member's sources of pain, stress and discomfort. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members provide all authorized palliative care. DHCS recommends that the palliative care team include but is not limited to the following team members: a doctor of medicine or osteopathy (Primary Care Provider if MD or DO); a registered nurse; a licensed vocational nurse or nurse practitioner (NP) (Primary Care Provider if NP); and a social worker. DHCS also recommends that there is access to chaplain services as part of the palliative care team. Chaplain services provided as palliative care are not reimbursable through the Medi-Cal program.

6. Care Coordination: A member of the palliative care team provides coordination of care, ensures continuous assessment of the member's needs, and implement the plan of care.

7. Pain, Stress and Symptom Management: The member's plan of care includes all services authorized for pain and symptom management. Adequate pain, stress and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address a member's pain, stress, and other symptoms.

8. Mental Health and Medical Social Services: Counseling and social services are available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. Provision of medical social services does not duplicate specialty mental health services provided by Alameda County Behavioral Health Care Services (ACBHCS). Furthermore, provision of medical and social services does not change AAH's responsibility for referring to, and coordinating with, ACBHCS, as delineated in APL 17-018 "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services," including any subsequent revisions.

9. AAH has a process to determine the type of palliative care that is medically necessary or reasonable for eligible members. AAH has an adequate network of palliative care providers to meet the needs of members.

10. AAH may, at its discretion and cost, authorize additional palliative care not described above. Examples of additional services offered by some community-based palliative care programs include a telephonic palliative care support line that is separate from a routine advice line and is available 24 hours a day/ 7 days a week, and expressive therapies, such as creative art, music, massage and play therapy, for the pediatric population.

F. Providers/ Network

1. Palliative care services may be authorized in the hospital, as part of the inpatient care treatment plan, outpatient (primary care, specialty care clinics), or by community-based settings, such as home health teams, or hospice entities. The Alliance offers a network of palliative care services to its members through various provider types and utilizes qualified providers who comply with the existing Medi-Cal requirements.

2. The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on the setting and needs of the members as long as the provider complies with the existing Medi-Cal requirements.

3. The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

4. The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website, Member Handbook, Member Services, Case Management, and member education materials.

F. Referrals and Authorizations

1. The Alliance identifies members eligible for palliative care by the following:
    - Screening for palliative care eligibility in basic Case Management, Complex Case Management, ECM providers, CBAS designees, Transitions of Care, and 2024 Managed Care Plan Transition for Special Populations.
    - Referrals from network providers, members/ family members/ legal-recognized decision-maker, including through case management. concurrent utilization review, and the general authorization process.
    - Population Health Management: Analysis of member data

G. Authorizations:

1. Palliative care services follow the general authorization process outlined in the Utilization Management (UM) policy and procedure UM-001 and UM-057 Authorizations Process. Authorizations for palliative care services are reviewed as outlined in UM-001 UM Authorizations Process and meet the timeliness standards as outlined in policy and procedure UM-051 Timeliness of UM Decisions.
2. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity.
3. Referral and care coordination for palliative services will be provided to the member within the time or distance access standard requirements.
4. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider manual, provider newsletters, educational materials and via the Alliance's website.

H. Grievance and Appeals

1. Member complaints related to the provision of palliative care services and authorization process are processed through the Alliance's Grievance and Appeals system in a manner consistent with grievance and appeals requirements set forth in APL 17-006 Grievance and Appeal Requirements and Revised Notice Templates

and "Your Rights" Attachments. The process is further described in policy and procedure G&A-001 Grievances and Appeals System Description.

2. The Alliance monitors and collects palliative care enrollment, provider, and utilization data to report to DHCS as specified. The Alliance ensures that their delegates comply with all applicable state and federal law and regulations and other contractual requirements as well as DHCS' guidance, including APLs. AAH communicates these requirements to all their delegated entities and subcontractors.

Delegation Oversight

The Alliance adheres to applicable state and federal laws and regulatory requirements, contractual requirements, other DHCS guidance, and accreditation standards for delegates and subcontractors. All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS / ACRONYMS

Hospice Care – defined as the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider.

2024 MCP Transition – Refers to changes to the Medi-Cal Managed Care Plans (MCPs) operating in specific counties slated to take effect on January 1, 2024, as a result of county-level Medi-Cal model change, changes to commercial MCP contracting, and the Kaiser direct contract.

Palliative Care – patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Interventions focus primarily on reduction and abatement of pain, stress, and other disease-related symptoms rather than interventions aimed at investigation and/or cure or prolongation of life. See Health and Safety Code §1339.31(b).

Special Populations – Members most at risk for harm from disruptions in care or who are least able to access Continuity of Care protections by request or who are identifiable in DHCS data or Previous MCP's data.

Terminally ill – defined in:
1. Title 42, CFR, §418.3 as a member whose medical prognosis, as certified by a physician, is such that his or her life expectancy is six months or less if the illness runs its normal course.
2. CA Health and Safety Code § 1368.1(a) as an incurable or irreversible condition that has a high probability of causing death within one year or less.

Transitions of Care (Population Health Management)– ensures Members are supported from the start of the discharge planning process, through their transition, until they have been successfully connected to all needed services and supports.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services
Claims
Compliance
Provider Relations and Contracting

RELATED POLICIES AND PROCEDURES

G&A-001 Grievances and Appeals System Description UM-001 Utilization Management
UM-008 Coordination of Care – California Children's Services
UM-011 Coordination of Care – Hospice and Terminal Illness
UM-051 Timeliness of UM Decisions
UM-057 Authorizations

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

1/04/2018, 3/21/2019, 5/21/2020, 5/20/2021, 6/28/2022, 10/19/2023, 12/18/2024

REFERENCES

- CALAIM: Population Health Management (PHM) Policy Guide, May 2024
- California Children's Services, #06-1011
- DHCS APL 13-014 Hospice Services and Medi-Cal Managed Care
- DHCS APL 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services
- DHCS APL 18-020 Palliative Care and Medi-Cal Managed Care
- DHCS APL 21-011 Grievance and Appeal Requirements and Notice and "Your Rights" Templates
- DHCS APL 22-006 Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services
- DHCS Managed Care Policy Letter 11-004.
- DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide, V7
- Medi-Cal Provider Manual "Evaluation and Management (E&M)
- Patient Protection and Affordable Care Act (ACA), Section 2302.
- Senate Bill 1004, Hernandez, Health Care: Palliative Care, Chapter 574, (2014): https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB1004
- Welfare and Institute Code (WIC) Section 14132.75

MONITORING

This policy will be reviewed on an annual basis to ensure it complies with regulatory and

contractual requirements.

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

POLICY AND PROCEDURE

Policy Number	UM-056
Policy Name	Standing Referrals
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, IHSS
Effective Date	3/01/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	7/17/2024

POLICY STATEMENT

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

POLICY

1. The Alliance shall maintain a referral management process and may delegate the referral management process to delegated entities.
   a) Delegated Entities shall maintain policies and procedures for referral management that includes reviews of requests for standing referrals for enrollees who require continuing specialty care or treatment for a medical condition or disease that is life threatening, degenerative, or disabling.

2. The Alliance shall establish and implement a procedure to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the Primary care Physician (PCP), in consultation with both the specialist, if any, and The Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or SCC.
   a) The Alliance may require the PCP to submit a treatment plan during the course of care or prior to the referral from the enrollee as determined by the Medical Director.
   b) If a treatment plan is necessary in the course of care and is approved by The Alliance, in consultation with the PCP, specialist, and enrollee, a standing referral shall be made in accordance with the treatment plan.

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

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

3. The Alliance shall establish and implement guidelines for standing referral requests for enrollees that required specialized medical care over a period of time and who have a life-threatening, degenerative, or disabling condition, to a specialist or SCC that has expertise in treating the condition or disease for the purpose of having specialist coordinate he enrollee's health care.
   a) The referral shall be made if the PCP, in consultation with the specialist or SCC, and Medical Director, determines that the continued specialized medical care is medically necessary for the enrollee.
   b) The Alliance may require the PCP to submit a treatment plan during the course of care or prior to the referral for the enrollee, as determined by the Medical Director.
   c) If a treatment plan is deemed necessary in the course of the care and is approved by The Alliance, in consultation with the PCP, specialist. SCC and the enrollee, a referral will be made accordance with the treatment plan.
   d) A treatment plan may be deemed unnecessary if The Alliance approves the applicable referral to a specialist or SCC.

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

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

which shall be evaluated with this policy.

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

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

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

PROCEDURE

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

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

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

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

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

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

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

8. Medical Director will forward the case with the final determination to the coordinator of record for appropriate notifications to PCP/Specialist and Member.

9. Annual Renewals

    a) Standing referrals are valid for up to one calendar year from the date of the latest determination.
    b) UM Staff will process authorizations with the approved number of visits based on the approved Treatment Plan.
    c) Requests for renewals to Standing Referrals are reviewed using the guidelines of this policy and the latest clinical information with a new Treatment Plan from PCP and Specialist.

10. Preventive Care:

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

DEFINITIONS / ACRONYMS

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.

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

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

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

Medically Necessary (Medi-Cal Program): means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical Practitioner, exercising prudent clinical judgment, would provide to a Member

for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

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

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

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

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

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

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

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

Specialty Care Center means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise

in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Standing Referral means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

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

Utilization Management

RELATED POLICIES AND PROCEDURES

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

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

3/01/2018, 4/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 9/19/2023, 7/17/2024

REFERENCES

1. California Health and Safety Code – HSC § 1374.16
2. DHCS Contract Exhibit A, Attachment 9, Access and Availability, Section 7
3. California Welfare and Institutions Code Section 14450.5
4. California Health and Safety Code – HSC § 1367.01

MONITORING

Delegated Medical Groups

- The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
- The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
    - Internal Monitoring
        - The Utilization Management Department, on a routine basis, reviews:
            - 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.

- Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
- Quarterly reports of authorizations and claims for non-network specialty referrals and standing referrals

POLICY AND PROCEDURE

Policy Number	UM-057
Policy Name	Authorization Service Request
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Utilization Management Director
Lines of Business	MCAL, IHSS
Effective Date	11/02/2004
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

OVERVIEW

Alameda Alliance for Health (Alliance) maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.

The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to **CA Health and Safety Code §1367.01, 1367.665, 1374.141**, and **42 CFR 438.900(d)** and **42 CFR Subpart K.**

POLICY

A. The Alliance develops, reviews, and approves at least annually, lists of services that are exempt from prior authorization, services rendered by the Alliance direct-network that do not require authorization, services that are appropriate for auto-authorization, and services that require prior authorization and clinical review for medical necessity.

B. The Alliance shall communicate to all contracted health care practitioners the procedures, treatments, and services that require authorization and the procedures and timeframes necessary to obtain such authorizations.

1. Communication shall include the data and information the Alliance uses to make determinations (e.g., UM criteria, patient records, conversations with appropriate physicians) that guide the UM decision-making process.
2. The Alliance publishes its Clinical Practice guidelines on the Alliance website for use by any contracted or non-contracted provider. These guidelines cover both clinical care and Preventive Care:
    i. alamedaalliance.org/providers/provider-resources
    ii. alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/
3. The Alliance provides written information on criteria and evidence-based practice guidelines used for decision making in accordance with the UM-054 Notice of Action Policy for both contracted and non-contracted providers.

C. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as Prior Authorization (PA) timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the Evidence of Coverage (EOC). If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service. If the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, the Alliance will do the following:

    1. Notify the Member of their right to access their medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.
    2. Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their Primary Care Physician (PCP), unless the enrollee objects.
    3. Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.
    4. Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

D. The Alliance ensures that there is parity between the provision of medical/surgical care and behavioral health care in all aspects of UM policies and procedures. These include timeframes, classification of determinations, qualifications of decision makers, notification of outcomes, use of clinical criteria, disclosure of criteria to members and providers, authorization requirements, in-network, or out-of-network requirements, and all other regulatory requirements related to utilization management. For Group Care members receiving behavioral health services, medical necessity determinations are based on non-profit professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction

Medicine (ASAM), World Professional Association for Transgender Health (WPATH), Counsel of Autism Services Providers, American Psychiatric Association, and the American Psychological Association.

E. The below services are exempt from prior authorization, based on regulatory requirements:
    1. Emergency Services, whether in or out of Alameda County; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
    2. Urgent care, whether in or out of network
    3. Primary Care Visits
    4. Preventative Services
    5. Immunizations/Vaccines
    6. Annual Cognitive Assessment for Medi-Cal members over 65 without Medicare.
    7. Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
    8. Basic perinatal care – a woman can go directly to any network provider for basic perinatal care
    9. Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
    10. Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention
    11. HIV testing and counseling
    12. Minors do not need authorization for:
        a. Sexual or physical abuse
        b. Suicidal ideations
        c. Pregnancy care
        d. Sexual assault
        e. Drug and alcohol abuse treatment
    13. Biomarker testing which is FDA approved
        a. For all lines of business (LOB) prior authorization is exempt for members with advanced or metastatic cancer stage 3 or 4, or for cancer progression or reoccurrence in members with advanced or metastatic cancer stage 3 or 4 (**Health & Safety Code §1367.665**).

F. The below services provided by the Alliance's direct network do not require prior authorization:
    1. Specialty visits (initial and follow-up visits)
    2. Mental Health and Substance Use Disorder outpatient visits
    3. Services/codes that have been reviewed and approved at least annually by the Alliance UM Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC) to remove prior authorization requirements

G. The Alliance considers the following factors in determining services that do or do not require prior authorization, concurrent review, or retrospective review:
    1. Regulatory/Contractual guidelines
    2. Member access to services
    3. Utilization patterns:
        a. Volume of authorizations

b. Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews
4. Patient safety
5. Provider consistency in scope of utilization requests

H. Auto-authorization is an authorization approval process that does not require clinical review and can be completed by a non-clinical UM staff. The Alliance considers the following factors in determining services to be on auto-authorization:
1. Regulatory/Contractual guidelines
2. Member access to services
3. Utilization patterns:
a. Volume of authorizations
b. Volume of authorizations approved, denied, modified, or deferred after medical necessity reviews
4. Patient safety
5. Provider consistency in scope of utilization requests

The list of services on auto-authorization is reviewed and approved at least annually at UMC and QIHEC. UM staff will process requests in accordance with the auto-authorization guidelines after approval by UMC and QIHEC (see attachment section of the policy).

I. Services for which authorization is required include, but are not limited to:

1. Out-of-network providers/ services/ facilities.
2. Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).
3. Selected Mental Health Care and Substance Use Disorder treatment (ex. Applied Behavioral Analysis (ABA), inpatient, residential treatment, partial hospitalization, intensive outpatient treatments, neuropsychiatric testing, ECT).
4. Selected major diagnostic tests.
5. Home Health Care/ Private Duty Nursing care.
6. Selected durable medical equipment.
7. New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.).
8. Medications not on the Alliance approved drug list and/or exceeding the Alliance's monthly medication limit.
9. CBAS services.
10. Inpatient admissions (non-emergency).
11. Inpatient hospice care.
12. Inpatient abortions.
13. Skilled nursing facilities admissions.
14. Long-term care (LTC) Custodial Nursing Facility admissions.
15. Intermittent Care Facility for the Developmentally Disabled (ICF/DD) admissions.
16. Subacute Admissions.
17. LTC Skilled nursing facilities Bed Hold/ Leave of Absence.
18. Major Organ Transplant Services.

19. Out of Network Second opinion.
20. Podiatry services.
21. Acupuncture, greater than four (4) visits per month for Adults. Limits do not apply for children under the age of 21.
22. Chiropractic.
23. Treatment and services related to gender dysphoria.

J. Immunization/Vaccination
    1. Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, the Alliance will provide available information on the status of the member's immunizations to the LHD clinic. The Alliance will pay claims from LHD clinics sent with supporting immunization records.

K. Biomarker testing is a covered benefit for the purposes of medically necessary diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment options.
    1. For all LOB: members with advanced or metastatic stage 3 or 4 cancer, or for cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. This is intended to remove barriers for members with late-stage cancer, allowing them to access cancer biomarker testing to help inform their treatment in order to better expedite care. The Alliance will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6. The Alliance will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.
        a. Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the Medi-Cal website to ensure DHCS lists these codes as billable and payable during any given year. As new coding updates are released by CMS, the Alliance coding list will be updated at least annually. Any updates are configured in the Alliance UM and Claims systems to not require PA for in-network providers for Medi-Cal LOB only.
    2. For Group Care members, as required in the Cal. Health & Safety Code section §1367.667, the Alliance covers medically necessary biomarker testing, subject to utilization review, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions. Biomarker tests that meet any of the following will be covered:
        a. A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug
        b. A national coverage determination made by the Centers for Medicare and Medicaid Services
        c. A local coverage determination made by a Medicare Administrative Contractor for California
        d. Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review

by experts who are not part of the editorial staff
e. Standards set by the National Academy of Medicine

Biomarker testing is provided to Group Care members in a manner that limits disruption in care, including the need for multiple biopsies or biospecimen samples. Any restricted or denied use of biomarker testing for the medically necessary reasons noted above are subject to grievance and appeal processes.

L. Non-Benefit Codes
1. The Alliance may cover a non-covered service if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the non-covered benefit is medically needed.
    a. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business
    b. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process
    c. All potential denials of these services will go to the MD for review and final determination

M. Unlisted Codes
1. The Alliance may cover an unlisted service codes if it is medically necessary. The Provider must submit a pre-approval (Prior authorization) request to the Alliance Utilization Management Department with the reasons the unlisted service codes is medically needed.
    a. Exceptions never covered are Infertility Preservation services for Medi-Cal lines of business, Cosmetic Surgery for all lines of business and Experimental/ investigational services or drugs for all lines of business
    b. The Alliance UM Nurse Reviewer will use UM criteria (DHCS and/ or MCG), patient records to guide the UM decision-making process
    c. All potential denials of these services will go to the MD for review and final determination

N. Standard Fertility Services

1. Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment).

2. For Medi-Cal members, the following fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos, are not covered.

O. Indian Health Service Programs
1. The Alliance will ensure qualified Members have timely access to Indian Health Service (IHS) Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance

Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).

P. Appropriate Classification of Determination
   1. UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.
   2. Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render it covered then a medical necessity decision is needed.
   3. Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

Q. The Alliance service types are processed as:
   1. Prior Authorization
   2. Concurrent, inpatient
   3. Concurrent, Outpatient (care currently underway)
   4. Post-Service/Retrospective Review

R. The Alliance authorization determinations are documented as:
   1. Approved
   2. Modified
   3. Denied
   4. Delayed

S. UM Decision Making
   1. The Alliance uses licensed health care professionals to make UM decisions that require clinical judgment. The following staff may approve services:
      a. Qualified health care professionals (licensed physicians), supervise review decisions, including service reduction decisions.
         Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease. 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.
      b. A qualified physician, doctoral Behavioral Healthcare (BH) practitioner, or pharmacist (when applicable) shall review denials, modifications, delays, terminations that are made, whole or in part, based on medical necessity.
      c. UM Reviewers make UM authorization approval decisions based on UM Committee approved auto authorization criteria and other UM Committee approved UM criteria UM-001, and auto authorization criteria.
         i. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria and Policy RX 002
      d. Qualified Behavioral Health (BH) Reviewers staff make BH authorization

approval decisions based on QIHEC and UM Committee approved BH UM criteria.

i. See UM-012 Care Coordination policy regarding approved BH UM criteria.

e. A qualified physician, or doctoral behavioral healthcare practitioner as appropriate, shall review any behavioral healthcare denial of care based in whole or in part on medical necessity.

f. Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria.

g. Administrative Denials: Qualified non-clinical staff may make non-medical necessity decisions due to non-eligibility and Retro Authorization submission greater than 90 days.

i. Retro Authorizations >90 days will still be reviewed for Medical Necessity

h. Pharmacy technicians make pharmacy authorization approval decisions based on UM P&T Committee approved Pharmacy Guidelines and Policy RX-002

T. In instances where the Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the Alliance shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe or as soon as the Alliance becomes aware that it will not meet the timeframe. A deferral notice is warranted if the Alliance extends the timeframe up to an additional 14 calendar days because either the beneficiary or provider requests the extension, or the Alliance justifies a need for additional information and how the extension is in the best interests of the beneficiary.

U. The Alliance shall make all UM decisions and notifications within the required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards. If required timeframes differ, the Alliance shall adhere to the strictest standard.

V. The Alliance shall process the assessment of appropriateness of medical services on a case-by-case or aggregate basis when UM requests for prior authorization are received before services are provided taking into consideration the following:

1. Determining and ensuring response appropriate to urgency of request.
2. Determining and ensuring adequate clinical information is provided to review the request and if not, to work with the requesting provider to obtain for additional specific information needed to review the request.
3. Ensuring that correct UM criteria are selected for review of request.
4. Ensuring appropriate review of request by the appropriate level of UM staff and/or Medical Director/ Physician / doctoral BH Practitioner/ Pharmacist.
5. Ensuring timeframes are met for UM determination of the request and notifications to practitioner and member.

W. When determining medical necessity, the Alliance gathers all relevant clinical information consistently to support UM decision making. The Alliance requires enough clinical information necessary to render a decision. If all the relevant information necessary to make the determination is not available, the Alliance works with the requesting providers to obtain the information in a timely manner.

X. Rescission

1. No approved authorization shall be rescinded or modified after the provider renders services from UM decisions in good faith for any reason, including, but not limited to, subsequent rescission, cancellation, or modification of the member's contract or when the Alliance did not make an accurate determination of the member's eligibility.

Y. The Alliance ensures verbal and written communications to the Member and Providers for UM decisions are provided using the appropriate approved templates and within the UM timeliness standards.

Z. Authorization of Enhanced Care Management (ECM)

1. Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:
    a. Routine requests not to exceed five (5) days.
    b. Expedited requests not to exceed 72 hours.
2. Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:
    a. Provider notification not to exceed 24 hours, (oral or written) after decision.
    b. Written notification to provider and member not to exceed two (2) working days after decision.
3. The Alliance will authorize ECM for a minimum of six (6) months for each request.
    a. Delegated ECM Providers and/ or their subcontractors must follow Alliance authorization requirements, including adjudication standards and referral documentation.
4. ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.
5. The Alliance will identify members who meet the criteria as a member of a population of focus and refer the member to an ECM provider for outreach.
6. The Alliance will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.

Y. Authorization of Community Supports (CS) Services

1. Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:
    a. Routine requests not to exceed five (5) business days.
2. Expedited requests not to exceed 72 hours.2. Notification time frames for authorization request determination decisions for CS will follow regulatory UM timelines, for example:
    a. Provider notification not to exceed 24 hours, (oral or written) after decision.
    b. Written notification to provider and member not to exceed two (2) working days after decision.

AA. Post Service/Retrospective Review Process

1. The Alliance does not accept post-service or retrospective authorization requests for non-emergent or non-urgent services that would require prior authorization more than 90 days past the date of service. The exception criteria under which a post service / retrospective request greater than 90 days after the date of service which may be considered are:

    a. Member eligibility issues, i.e., retrospective eligibility, unable to validate eligibility at

time of service, incorrect eligibility information at time of service.b. In-patient services where the facility is unable to confirm enrollment with the Alliance.

2. If the Alliance receives a request for services >90 days from the Date of Service the request will be reviewed for Medical Necessity and then processed as an administrative denial.

a. Medical Necessity review will follow the typical UM process

b. All potential Medical Necessity denials will be sent to the Medical Directors for review.

BB. On January 1, 2024, Alameda County transitioned to a Single Plan Model county, and Medi-Cal recipients transitioned from a previous MCP to Alameda Alliance for Health (Alliance) as their Medi-Cal Managed Care Plan (MCP). Before and during the transition, The Alliance adhered to the requirements of All Plan Letter (APL) 23-018 Managed Care Health Plan Transition Policy Guide (Policy Guide), which establishes the 2024 Managed Care Plan Transition Policy Guide as the DHCS authority, along with the applicable Contract, and any incorporated APLs or guidance documents incorporated into the Policy Guide by reference, regarding the 2024 MCP transition. The continuity of care authorization process for members who transitioned into the Alliance adhered to the requirements of the 2024 Managed Care Plan Transition Policy Guide and APL 22-032 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.

1. The Alliance policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.
2. Particular attention and resources were focused on members in Special Populations:
    a. Adults and children with authorizations to receive Enhanced Care Management (ECM) services
    b. Adults and children with authorizations to receive Community Supports (CS)
    c. Adults and children receiving Complex Care Management (CCM)
    d. Enrolled in 1915(c) waiver programs
    e. Receiving in-home supportive services (IHSS)
    f. Children and youth enrolled in California Children's Services (CCS)
    g. Children and youth receiving foster care, and former foster youth through age 25
    h. In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
    i. Taking immunosuppressive medications, immunomodulators, and biologics
    j. Receiving treatment for end-stage renal disease (ESRD)
    k. Living with an intellectual or developmental disability (I/DD) diagnosis
    l. Living with a dementia diagnosis
    m. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
    n. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
    o. Receiving specialty mental health services (adults, youth, and children)
    p. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
    q. Receiving hospice care

r. Receiving home health
s. Residing in Skilled Nursing Facilities (SNF)
t. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
u. Receiving hospital inpatient care
v. Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
w. Newly prescribed DME (within 30 days of January 1, 2024)
x. Members receiving Community-Based Adult Services (CBAS)

3. See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

CC. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:

1. Contracted providers are informed in the service agreements, by accessing the Provider Manual, the Prior Authorization Grid information located on the Alliance website and are available upon request.
2. Non-contracted providers are informed via the Alliance website/Section – Authorization.

PROCEDURE

A. Pre-Service Review

1. Authorization requests are submitted by phone, fax, in writing, or via secure portal.
2. Upon receipt of the authorization request, the UM Coordinator will review the request for:
   a) Member eligibility
   b) Completeness of the request
      i. Presence of medical codes, e.g., ICD-10, CPT, HCPCS
      ii. Presence of medical records.

3. Once the authorization request review is complete, the UM Coordinator enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.

4. Upon selecting the authorization request from the queue, the assigned UM Coordinator reviews the pre- service authorization request against benefit grid, approved auto authorization criteria. The pre-service request workflow:
   a) For requests meeting auto authorization criteria, the UM Coordinator approves the request following UM guidelines via Auto Authorization.
   b) For requests not meeting Auto Authorization Criteria, the UM Coordinator routes the request to the UM Nurse/ doctoral BH Reviewer/ or Pharmacy technician.

5. The UM Nurse/ BH Reviewer/ or Pharmacy technician performs a medical necessity review of the pre-service authorization request and clinical information presented using the appropriate UM criteria, as noted in UM-001 Utilization Management Policy and the UM Program Description.

a) The UM Nurse / BH Reviewer/ or Pharmacy technician documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
b) The UM Nurse /BH Reviewer/ or Pharmacy technician workflow includes:
c) For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer/ or Pharmacy technician approves the request and generates the Member and Provider approval notification.
d) For authorization requests not consistent with the request (i.e., conflicting CPT codes to diagnosis, conflicting HCPCS to documentation, etc.), not meeting UM / BH/ or Pharmacy Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer forwards the request to the UM Physician/ Medical Director/ doctoral BH/ or Pharmacist Reviewer for review.

6. Minimum Clinical Information for Review of UM Requests for Authorization
   a) Request for services shall be reviewed in accordance with approved UM criteria and the member's benefit structure.
   b) When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
   c) Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:
      i. Office and hospital records
      ii. A history of the present problem
      iii. A clinical exam
      iv. Diagnostic testing results
      v. Treatment plans and progress notes
      vi. Patient psychosocial history
      vii. Information on consultations with the treating practitioner
      viii. Evaluations from the other health care practitioners and providers
      ix. Photographs
      x. Operative and pathological reports
      xi. Rehabilitation evaluations
      xii. A printed copy of criteria related to the request.
      xiii. Information regarding benefits for services of procedures
      xiv. Information regarding the local delivery system
      xv. Patient characteristics and information
      xvi. Information from responsible family members
      xvii. Minimum Data Set (MDS)
      xviii. Preadmissions Screening and Resident Review (PASSR)
      xix. Bedbound Certification

B. Missing Clinical Information:
   1. Formal requests for missing information can be made either by phone or in writing.
      a) Missing information includes:
         i. Incomplete name, ID number, contact information.
         ii. Diagnosis or Service codes

iii. Incomplete Attachments
iv. Required Title XXII forms

2. When clinical information is missing in the request and the information can be received within the same day, UM staff (i.e. Coordinators, Nurses, Pharmacists), and if needed the Physician / Medical Directors / doctoral BH Reviewer/ or Pharmacist shall contact the requesting provider by phone to request missing clinical information.
   a) Call attempts should be documented in the authorization request case. Up to three (3) attempts will be made:
      i. One (1) Fax and two (2) phone calls: The Authorization Coordinator shall make the first call and generate a fax request and make an additional phone call outreach. The UM Nurse / BH Reviewer may also attempt phone outreach, and/or the Medical Director/ Physician / doctoral BH / Pharmacist Reviewer for a Peer-to-Peer request.

C. Request for additional information
   1. Requests for additional information are considered deferrals or delays, and authorizations are pended until reasonably necessary information is received to make a determination.
   2. In instances where UM clinical staff cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the UM Physician / Medical Director BH Reviewer / or Pharmacist will identify the information necessary and shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe.
   3. Formal requests for additional information must be made in writing to the provider and the Member using the most recent DHCS or Alliance templates.
   4. For routine or expedited requests, an extension of up to 14 calendar days from the day of receipt may be granted if either the beneficiary or provider requests the extension, or the Alliance justifies a need for additional information and how the extension is in the best interest of the beneficiary.
   5. The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.
   6. Upon receipt of all information reasonably necessary and requested, UM Nurse / Physician/ Medical Director / BH Reviewer / or Pharmacist may approve the request for authorization within five (5) business days or 72 hours for standard and expedited requests, respectively.
      a) If there is no response or the requested additional information is not received, the UM Nurse Reviewer will continue the review with the available information.
   7. A full description of the Member and Provider Notice of Action communication is found in UM - 054 Policy Notice of Action.

D. Medical Director / Physician Reviewer Review
   1. The Medical Director / Physician / doctoral BH Reviewer reviews pre-service authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director / Physician Reviewer / doctoral BH reviews the information summary provided by the UM Nurse / BH Reviewer, the clinical information, and the appropriate UM Criteria.
      a) The Medical Director / Physician/ doctoral BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
      b) To evidence appropriate professional review, each UM case must include one of the

following:

i. The reviewer's written signature or initials
ii. The reviewer's unique electronic signature or identifier on the denial notation
iii. A signed or initialed noted from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.

2. Once the Medical Director / Physician/ doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse / Coordinator /BH Reviewer / or Pharmacy technician for processing:
   a) Approvals: The UM Nurse / Coordinator / BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes.
   b) Delays, Denials, Modifications, or Terminations: The UM Nurse / Coordinator / BH Reviewer / or Pharmacy technician processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

E. Peer to Peer Discussions
   1. For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with the Alliance decision maker. Providers are notified of this process in the UM determination notifications.
      a) When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with the Alliance UM decision maker.
      b) Oral request includes reading the standard statement for availability of the discussion exactly as identified in the NOA letter.
         i. "The Alliance has reviewed your request for <<Insert Member Name>>. The Alliance made a determination that this service is not medically necessary. You may also contact the Medical Director / Behavioral Health / Pharmacist reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit."
   2. The Alliance provides easy access for Providers and utilizes the Alliance UM telephone number to serve as the entry point of contact.
   3. UM / BH Staff / Pharmacy will answer the UM calls and obtain the key information to have the UM decision maker return the call:
      a) Member name and ID#
      b) Referral #
      c) Name of the Physician requesting the return call.
      d) Contact number for the requesting Physician.
      e) Best time to reach the requesting Physician.
   4. UM / BH/ or Pharmacy Staff will note the request for the discussion in the TruCare case and notify the appropriate UM decision maker.
      a) If the Alliance UM / BH/ or Pharmacy decision maker is not available, the Staff will task the request to the UM decision-maker for the day.
   5. Every attempt is made to return calls on the same day.
      a) Two (2) attempts will be made within a 24-hour period. Each attempt will be documented in the TruCare case.
      b) The Alliance Physician / Medical Director / doctoral BH Reviewer / Pharmacist will document all outreach attempts in TruCare.

6. The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:
   - In the denial notification, ***or***
   - By telephone, ***or***
   - In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.
7. The organization includes the following information in the denial file:
   - The denial notification, if the treating practitioner was notified in the denial notification.
   - The time and date of the notification, if the treating practitioner was notified by telephone.
   - Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

F. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Physician / Medical Director/ / doctoral BH Reviewer / Pharmacy does not have the clinical expertise in treating the requested serviced to render the UM determination, the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist may consult with a Board Certified Consultant to assist in making the medical necessity determination.
   1. When using a Board-Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will utilize the recommendation in rendering the final UM determination.

G. Out of Network/Non-Contracted Providers
   1. The Alliance requires services to be provided within the contracted network.
      a) Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which the Alliance does not have a contracted provider or provider type in in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or Long Term Care nursing facility capacity:

   2. When services are not available within the network:
      a) At the time of the initial processing of the authorization request, the AC will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue and documents the out of network reason for the request.
      b) If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdraw in the case notes and closes the case.
      c) If the decision is to continue using a non-contracted provider, the AC routes the request to the UM Nurse / BH Reviewer / or Pharmacist to determine if the service is medically necessary and the status of available providers within the network to provide the service.
      d) The UM Nurse / BH Reviewer / Pharmacist reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.
         i. If determined services are medically necessary but not available within the Alliance network within the applicable time and distance and timely access standards, the UM

Nurse / BH Reviewer / or Pharmacist reviews with the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist to determine if the non-contracted provider is the most appropriate and approve for initiation of one-time Letter of Agreement (LOA) through Provider Contracting.

ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM Nurse / BH Reviewer reviews case with the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist to possible re- direct into the network.
   (i) If determination is to re-direct, the UM Nurse / BH Reviewer / Pharmacist will confirm with the newly identified provider that the services can be provided and provided within the applicable time and distance and timely access standards.
   (ii) A referral is made for care coordination to assist the member to navigate the redirected care to a contracted provider.

e) For Out of Network Providers, Medi-Cal covered transportation to the Out of Network provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))

H. Services that require prior authorization, but no prior authorization obtained

1. Post-Service requests that **meet** the exception criteria and are submitted within 90 calendar days from the date of service, (when there is no claim on file) will be processed through the UM / BH / Pharmacy Department using medical necessity review criteria.
   a) Retrospective/post service requests shall not be considered urgent as the service has already been provided. The urgent requests will be reviewed by a Physician / Medical Director / doctoral BH Reviewer / or Pharmacist and changed to a routine urgency status.
2. Post-Service requests that **do not meet** the exception criteria and are submitted beyond 90 calendar days from the date of service, (when there is no claim on file) will be denied as services required prior authorization and no prior authorization was obtained.
   a) UM Coordinator will review post-service request to ensure:
      i. Member was eligible at the time of services.
      ii. Services required prior authorization.
      iii. Review documentation to ensure prior authorization was not given by a representative of the organization, i.e., Customer Service Notes, PCP, After Hours staff documentation.
   b) If no documentation is found to support potential prior authorization of the service, the UM Coordinator routes the case to the UM Physician / Medical Director / doctoral BH Reviewer / or Pharmacist for potential denial.
   c) If documentation is found to support a representative provided authorization to the vendor or facility for the service, the UM Coordinator will document the findings and route the case to the UM Nurse / BH Reviewer / or Pharmacist to confirm the services authorized match the services requested.
      i. UM Nurse / BH Reviewer / or Pharmacist will assess the documentation and confirm the prior authorization was related to the requested service.
         (i) If the services match, the case will be completed as approved and closed according to policy.
3. Post Service/Retrospective requests that meet the exception criteria **and** are submitted <u>greater than 90 calendar days</u> from the date of service.

a) Services are reviewed for medical necessity and if there is an exception to prior authorization based on UM Policy.

4. Post Service/Retrospective requests that do not meet the exception criteria **and** are submitted greater than 90 calendar days from the date of service:
   a) Services will be denied as "no authorization obtained for service that required prior authorization."
      i. For telephonic request received as inquires, Providers will be reminded of the policy and will be instructed they may submit the medical records with the claim for review.
   b) UM Coordinator will route request to the Medical Director / doctoral BH Reviewer / or Pharmacist for potential denial.
   c) The Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will review the services to ensure documentation elements support prior authorization was required but no authorization obtained.
      i. If documentation supports prior authorization was required and not obtained, Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will document findings and deny case as "no prior authorization obtained."
      ii. If documentation supports prior authorization was required and internal documentation shows authorization was obtained, the Physician / Medical Director / doctoral BH Reviewer / or Pharmacist will document findings for approval along with the reasons.
   d) Case is routed back to the UM Coordinator to complete the member and provider notifications.
   e) UM Coordinator will complete the member and provider notifications as defined in UM-054 Policy Notice of Action.

I. Potential Quality Indicator (PQI)
   1. If during a UM review process, staff identifies a potential quality of care issue, UM / BH / Pharmacy staff will fill out the PQI Service Request (SR) referral via HealthSuite and forwards to the QI department for review in accordance with QI-104 Potential Quality of Care Issues.

J. Referrals to Care Management
   1. If during a UM review process, staff identifies a member may benefit from care management or care coordination, including assisting with redirecting services from an Out of Network Provider to an contracted Provider, EPSDT Care Coordination, Enrollment in an Oncology Program, CCS verification, Behavioral Health, High Risk Transitions of Care Services, or a specific Community Supports/ Complex Care Coordination/ ECM service needs, then the UM staff will complete the Care Management / CCS / BH Referral Form as potential candidate for care management. The form is then forwarded to the Care Management Department / BH for review and assistance in accordance with Care Management / BH Policies.

K. Reporting and Tracking
   1. All pre-service requests are entered into the Alliance clinical information system, TruCare, with appropriate documentation reflecting management of the referral including time frames.
   2. The HealthCare Analytics department has developed a series of reports which track authorization requests by type, determinations, and timeliness. Reports are produced daily to monitor staff productivity and monthly to report department performance.

3. Monthly report summaries of UM activities are reported to the UM Committee for tracking and trending activities as well as to identify opportunities for process improvements.

L. The Alliance Medical Management Referrals for Autism Services
   1. A PCP, a Regional Center, or a family member may refer members to receive services by contacting the BH Department.
   2. All BH related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946 will be routed to the BH Team for referral processing.
   3. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or autism.
      a) The BH team will submit any request for non-BH services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.
      b) UM Staff will process referral requests as defined in Sections 3.1
      c) UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.

M. The Alliance UM / BH / Pharmacy departments provide oversight of delegated entities' compliance with state and federal regulations and Alameda Alliance's delegated UM activities, which includes, but are not limited to, annual, focused, and supplemental audits/file reviews, and other various types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions for non-eligibility.

B. **Auto Authorizations:** Pre-service authorization requests that do not require clinical review and may be completed by a non-clinical staff member using established UMC approved guidelines.

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

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

E. **Biomarker:** A diagnostic test, single or multigene or an individual biospecimen, such as tissue, blood or other bodily fluids for DNA or RNA alternations, including phenotypic characteristics of a malignancy to identify an individual with a subtype of cancer to guide treatment.

F. **Criteria** means systemically developed, objective, and quantifiable statements used to assess

the appropriateness of specific health care decisions, services, and outcome.

G. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.

H. **Doctoral Behavioral Health Reviewer:** A licensed Psychiatrist or Psychologist who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical area of practice.

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

J. **Medically Necessary (Group Care Program for Medical Care):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. [2013 Group Care Program EOC, page 90)

K. **Medically Necessary (Group Care Program for Behavioral Health Services):** "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. ((iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. (HSC 1372.74(a)(3)(A))

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

i) Consistent with nationally accepted standards of medical practice:

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

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

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

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

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

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

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

N. **Member:** Any eligible beneficiary who has enrolled in the Alliance and who has been assigned to or selected a Plan.

O. **National Committee for Quality Assurance (NCQA**): A non-profit organization committed to evaluating and public reporting on the quality of health plans and other health care entities.

P. **Non-Contracted Provider:** A provider of health care services who is not contractually affiliated with the Alliance.

Q. **Post Service or Retrospective:** Utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

R. **Prior Authorization:** A type of Organization Determination that occurs prior to services being rendered.

S. **Provider:** Any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

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

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

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

V. **UM / BH Reviewer:** A Registered Nurse, Physician Assistant, Psychologist, or Licensed Mental Health clinicians (Licensed Clinical Social Workers, Licensed Marriage and Family Therapists) who is qualified by scope of practice, license, and experience in the use of criteria sets to evaluate clinical factors. Board Certified Behavioral Analysts and licensed qualified autism providers are qualified by scope of practice, license or credential and experience in the use of criteria set to clinically autism services. They apply QIHEC and UM Committee approved criteria to authorize care for members meeting the criteria within their scope of practice.

AFFECTED DEPARTMENTS/PARTIES

All departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. Prior Authorization Grid for Medical Benefits on The Alliance website, Provider Section,
2. BH-001 Behavioral Health Services
3. BH-002 Behavioral Health Services
4. BH-005 Care Coordination-Behavioral Health
5. BH-006 Care Coordination-Substance Abuse
6. CM-002 Coordination of Care
7. CM-009 ECM Program Infrastructure
8. QI-104 Potential Quality of Care Issues
9. QI-133 Inter-Rater Reliability (IRR) Testing for Clinical Decision Making
10. RX-002 PA Review Process
11. UM-054 Policy Notice of Action
12. UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care

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, 1/4/2018, 4/12/2018, 3/21/2019, 1/16/2020, 5/20/2021, 3/22/2022, 02/21/2023, 6/20/2023, 12/19/2023, 7/17/2024, 12/18/2024

REFERENCES

- SB 600, Section 1374.551. (a)
- "May directly or indirectly cause" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
- Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).
- DHCS Provider Manual, Family Planning, June 2022, page 1.
- DHCS Contract, Exhibit A, Attachments 5, 9, 13
- Title 22, Section 51159
- 28 CCR, §1300.51 (d)(I-6)
- Health & Safety Code, Section 1367.01, 1367.665; 1370.6
- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- 42 CFR 438.900(d)
- 42 CFR Subpart K
- NCQA Standards, Utilization Management
- WIC Section 14197
- APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates
- APL 22-010 Cancer Biomarking Testing
- APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

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.

Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. Consistent with HSC Section 1374.721(e)(7), the Alliance ensures interrater reliability pass rate of at least 90% and, if this threshold is not met, immediately provides for the remediation of poor interrater reliability. The Alliance also ensures interrater reliability testing for all new staff before they conduct utilization review without supervision. See QI-133 for additional detail about the Inter-Rater Reliability Process.

POLICY AND PROCEDURE TEMPLATE

Policy Number	UM-058
Policy Name	Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving a Medical Exemption
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL
Effective Date	5/3/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	7/17/2024

POLICY STATEMENT

1. This policy describes The Alliance policy and process to ensure continuity of care for Medi-Cal beneficiaries who transition from fee-for-service (FFS) Medi-Cal into Medi-Cal managed care that are included on the Exemption Transition Data report.

2. The Alliance shall maintain an established process for providing required services for Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan.

3. The Alliance is required to consider a request for exemption from MCP enrollment that is denied as a request to complete a course of treatment with an existing FFS or nonparticipating health plan provider under H&S Code § 1373.96, and in compliance with the MCP's contract with DHCS and all other DHCS Continuity of Care APLs.

4. The Alliance must ensure that all beneficiaries continue to receive medically necessary Medi-Cal services and ensure new enrollees are entitled to receive continuity of care with their existing providers, including behavioral health providers, for the completion of those services to the extent authorized by law. The beneficiary's existing provider is identified by the National Provider Identifier on the MER.

5. The Alliance must meet the continuity of care timeframes that are specified in H&S Code § 1373.96. This continuity of care policy is in addition to the extended continuity of care policy for Seniors and Persons with Disabilities established under APL 11-019, APL 22-032 on continuity of care for Medi-Cal beneficiaries who transition into managed care, and other continuity of care APLs and DPLs.

6. The Alliance must treat every exemption listed on the Exemption Transition Data report (see Attachment A for data file format details) as an automatic continuity of care request for the identified beneficiary.

7. Once an MCP is notified that a beneficiary is on the Exemption Transition Data report, the Alliance must make every effort to ensure that the beneficiary is allowed to continue to receive ongoing medical/behavioral health care through his or her FFS or nonparticipating health plan provider(s) for the period specified in H&S Code § 1373.96 for a particular illness or condition, including behavioral health conditions. This requirement also applies to instances in which the provider identified on the MER is a specialist who is not included in the network of a subcontracted health plan, independent physician's association, medical group, or other entity to which the beneficiary is assigned.

8. The Alliance must attempt to at least two phone calls . If applicable, on the second failed call attempt a detailed voice message should be left explaining how the beneficiary can contact the MCP. After two phone call attempts, the Alliance sends a letter to the member. If there is still no response, the Alliance waits 5 business days and then makes an additional two phone call outreach attempts.

9. The Alliance must begin processing requests for continuity of care within five working days from their receipt of the request. In this case, receipt of the Exemption Transition Data report constitutes such a request. The Alliance must complete their responses to each request within 30 calendar days from the date the MCP receives it, or within 15 calendar days if the beneficiary's medical condition/behavioral health requires more immediate attention, such as upcoming appointments or other pressing care needs. If there is a risk of harm to the beneficiary, the request must be completed in three days. If a beneficiary voluntarily chooses to change MCPs, the completion of covered services shall be continued by the new MCP for a period of up to 12 months from the date of enrollment into Medi-Cal managed care.

10. The Alliance must provide information to beneficiaries about their continuity of care rights as well as to providers (both in and out-of-network) about the requirements.

a. The Alliance must, at a minimum, include information about continuity of care in provider training and new member orientation materials.

11. MCPs must oversee and remain accountable for the requirements in this APL even if they subcontract with another health plan, independent physician's association, medical group, or other entity. In addition, MCPs must monitor subcontractors to ensure compliance with this APL. If the beneficiary's FFS or nonparticipating health plan provider is not an in-network provider, the MCP must contact the provider and make a good faith effort to enter into a contract,

letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the beneficiary.

12. For coordination of care and care transition efforts required under H&S Code § 1373.96, DHCS strongly encourages MCPs to allow non-contracted providers to continue a beneficiary's treatment plan for other, non-contracted services, such as laboratory testing and durable medical equipment and maintenance.

13. A continuity of care request is considered completed when:

a. The beneficiary is informed of his or her right of continued access or if the MCP and the out-of-network FFS provider are unable to agree to a rate;
b. The MCP has documented quality of care issues; or
c. The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.
d. Rendering provider is a Medi-Cal Provider (Medi-Cal LOB only)

14. The Alliance may choose to work with a beneficiary's out-of-network doctor past the 12-month continuity of care period, but the Alliance is not required to do so.

15. The Alliance Information Technology Department maintains processes to extract the DHCS Exemption Transition Data Report. The IT Department will ensure distribution to the Alliance UM Department within 2 days for processing.

a. The data file includes beneficiaries who have had a MER denied in the past 45 days. The file contains information for both pending and active beneficiaries. The data file uses the most recent choice/default information on record. For beneficiaries who are pending and not yet active, The Alliance will use the data provided to contact the beneficiary and initiate the continuity of care process. If there is no exemption denial activity for beneficiaries enrolling, an empty exemption file will not be posted to the site.

PROCEDURE

1. DHCS provides a data file to notify MCPs of beneficiaries who received a MER denial in the past 45 days who have or will transition into an MCP. The Exemption Transition Data report is accessible on the Secure Data Exchange Services (SDES) website for California Health Care Options: http://healthcareoptions.maximus.com/sdes/.

a. The Exemption Transition Data report is posted to the SDES on a weekly basis using the same schedule and location of the Weekly Plan File (WPF). The file posting schedule is available for download from the SDES website by clicking on the SDES web link above. Authorized MCP representatives who have access to the WPF can access the exemption file.

2. The Alliance IT Department will extract the file and upload it to the secure UM folder for processing.

3. The UM Department staff will accept all identified MERs as automatic continuity of care requests and begin outreach to identified members and providers.

Initiation of CoC based a Medical Exemption Request for

4. The UM Specialist will review the MERs list. Each member will be assessed for:

    a. Ongoing eligibility with The Alliance

    b. Assigned Provider Network and PCP or assigned Direct Provider.

    c. Availability of Requested Provider in the Alliance Network

5. Timeframes for MER Requests:

    a. Begin processing requests for continuity of care within five working days from their receipt of the request. In this case, receipt of the Exemption Transition Data report constitutes such a request.

    b. Complete their responses to each request within:

        i. 30 calendar days from the date the MCP receives it, or

        ii. 15 calendar days if the beneficiary's medical/behavioral health condition requires more immediate attention, such as upcoming appointments or other pressing care needs.

        iii. If there is a risk of harm to the beneficiary, the request must be completed in three days.

    c. If a beneficiary voluntarily chooses to change MCP (The Alliance) to another MCP, the completion of covered services shall be continued by the new MCP for a period of up to 12 months from the date of enrollment into Medi-Cal managed care.

6. UM Clinical Specialist contacts the Member or Member's Authorized Representative to review the request and explain the process for CoC based on the denial of the MER.

    a. Outreach attempts:

        i. Two documented outreach calls within two (2) business days of identification.

        ii. If no responses:
            1. Send an outreach communication within five (5) business days of identification by the UM Department.

            2. Followed by two documented telephone calls 5 business days after the mailed communication.

b. When successful contact is made, staff obtain all necessary information to assist in coordination services, i.e., medical records, eligibility segments, claims.

7. UM Clinical Specialist contacts the requested Provider to ensure the Provider agrees to continue providing services to the member.

a. If the Provider agrees, the UM Clinical Specialist:

i. Contacts requested provider to ensure they will see member and provides the "statement of reimbursement".

ii. Reviews the applicable external databases to assess whether the Provider has any disqualifying quality of care issues.

b. If Provider declines to provide ongoing services, the UM Clinical Specialist will notify the Member and identify an in-network provider to continue the provision of services.

8. Once the Provider is confirmed qualified, the UM Clinical Specialists will:

a. Create UM authorization requests.

b. Review the requested services to ensure criteria are met and services are medically necessary.

c. Criteria (Health and Safety Code 1373.96):

i. **An acute condition:** An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

ii. **A serious chronic condition:** A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

iii. **A pregnancy:** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services

shall be provided for the duration of the pregnancy and immediately after the delivery for up to 12 months.

iv. **A terminal illness:** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

v. The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

vi. Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

d. The UM Clinical Specialist documents determination in authorization requests.

i. Approvals – UM Clinical Specialist contacts Member to inform them of the approval determination and next step. The UM Clinical Specialist:
    1. Notifies Provider Relations (PR) to begin Letter of Agreement process.
    2. Once approved by all parties, UM Clinical Specialist completes authorization request, generates, and sends Approval Notification to Member, Provider, assigned PCP and assigned Provider Group.

ii. For potential denials based on request not meeting service criteria or Provider refusing to see Member or accept rates, the UM Clinical Specialist routes case to the UM Medical Director/ doctoral level Behavioral Health Practitioner with all the information documented in TruCare authorization requests.

e. The UM Medical Director/doctoral level Behavioral Health Practitioner will review all available information and make final determination.

i. If determination is to approve, the UM Medical Director documents review in TruCare authorization notes section and routes to UM Clinical Specialist to complete communications. Documentation should include the type of CoC applicable to case and why services are met.

ii. If determination is to deny, the UM Medical Director/ doctoral level Behavioral Health Practitioner documents review in TruCare authorization notes section and routes to UM Clinical Specialist to complete Member communications. Documentation should include:

    1. Type of CoC applicable, why services are not met and the applicable denial reason; documents the applicable denial reason in the authorization request.

2. Confirmation that the services can be provided in-network and communication with PCP to obtain the necessary services and authorizations.

f. Development of Plan of Care

i. The Alliance UM Department UM staff will coordinate with OON Provider to obtain a copy of the plan of care during the OON service. The Plan of Care will be shared with the assigned PCP and/or Provider Group to ensure all services necessary to manage the identified treatment plan are in place or arranged.

9. The Member is notified of the ongoing assignment to the Primary Care Provider for all preventive services and non-CoC related services.

10. Transition to In-network

a. For approved CoC, Members will be informed of the approved services, frequency, and duration for services with the OON provider.

b. The Alliance will monitor open existing authorizations with OON providers by the identified UM report.

c. One month prior to the expiration of the OON authorization, the UM Department will coordinate with the Provider and the Member to begin transitioning back services to the in-network provider.

11. Delegation

a. For services that are the responsibility of the delegate, the UM Clinical Specialist will facilitate and coordinate with the assigned delegate CoC contact. The UM Clinical Specialist documents in the TruCare authorization request the name and phone number of the delegate contact, and the PG outcome. The authorization request determination is documented as a "deny – responsibility of PPG" and case is closed. Delegates are required to process the CoC request as defined by policy or regulation.

DEFINITIONS / ACRONYMS

1. **Medical Exemption Request (MER**) means a request for temporary exemption from enrollment into a managed care plan (MCP) only until the member's medical condition has stabilized to a level that would enable the member to transfer to an MCP provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to members transitioning from Medi-Cal FFS to a managed care plan. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above.

2. **Authorized Representative:** means a person other than the plan member who is authorized to receive confidential information related to the member, and who may speak on the member's behalf.

3. **California State Plan**: In response to the CMS guidance and in accordance with Title 42 Code of Federal Regulations Section 440.130(c), the Department of Health Care Services (DHCS) issued interim guidance on September 15, 2014 in APL 14-011 to include BHT services as a covered Medi-Cal benefit for beneficiaries under 21 years of age when medically necessary, based upon recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of ASD to the extent required by the federal government.2 BHT services, such as Applied Behavior Analysis (ABA) and other evidence-based interventions, professional services, and treatment programs, prevent or minimize the adverse effects of ASD, and promote, to the maximum extent practicable, the functioning of a beneficiary with ASD.

4. **Continuity of Care (COC):** means a process for ensuring that care is delivered seamlessly across a multitude of delivery sites and transition in care throughout the course of the disease.

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

6. **Fee-for-Service (FFS):** means a method of payment based upon per unit or per procedure billing for services rendered to an eligible beneficiary.

7. **Managed Care Provider (MCP):** means a participating provider or a contracted provider in a Medi-Cal Managed Care Health Plan.

8. **Medically Necessary or Medical Necessity:** Those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical practitioner, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain, that are: consistent with nationally accepted standards of medical practice:
    a. "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.
    b. For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
    c. For purposes of covered services for Medi-Cal members, the term "medically necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and

d. When determining the medical necessity of Covered Services for a Medi-Cal member under the age of 21, "medical necessity" is expanded to include the requirements applicable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT Supplemental Services as defined in Title 22, 51340 and 51340.1.

9. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), Alliance will apply the definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards as follows:
    a. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body enrollee, or otherwise medically necessary under 42 CFR §1395y;
    b. For Medi-Cal services: reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under Title 22 California Code of Regulations (CCR) Section 51303.

10. **Members:** Any eligible beneficiary who is enrolled in any of Alliance's product lines of business.

11. **Out of Network (OON):** means a non-participating provider or a non-contracted provider in a Medi-Cal Managed Care Health Plan.

12. **Primary Care Provider (PCP):** means a primary care physician or clinic responsible for coordinating, supervising, and providing primary health care services to a member, including but not limited to initiating specialty care referrals and maintaining continuity of care.

13. **Provider:** means primary care physicians, specialists, ancillary providers, clinics, and hospitals.

14. **Quality of Care Issue (DHCS definition)** means The Alliance can document its concerns with the with the Provider's quality of care to the extent that the Provider would not be eligible to provide services to any other Alliance members.

15. **Risk of Harm** is defined as an imminent and serious threat to the health of the member.

16. **Seniors and People with Disabilities (SPD):** means person(s) 65 years or older and/or individual(s) meeting one of the following criteria: he or she has a physical or mental impairment that substantially limits one or more of his/her major life activities; he or she has a record of such an impairment; he or she is regarded as having such an impairment.

17. **Treatment Authorization Request (TAR):** means a referral or request for services. Services may be initial or ongoing.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Member Services
Provider Relations
Compliance

RELATED POLICIES AND PROCEDURES

- UM-036, "Cont. Covered Services for Members with Terminated Providers"
- BH-002 Behavioral Health Services

REVISION HISTORY

5/3/2018, 4/16/2019, 3/18/2021, 3/22/2022, 6/20/2023, 7/17/2024

REFERENCES

1. All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data (Supersedes APL 14-012 and 14-013)
2. All Plan Letter 22-032 (Supersedes All Plan Letters 18-008, 15-019, 14-021, 13-023) Continuity of Care for Medi-Cal Beneficiaries Who Transition Into Medi-Cal Managed Care
3. All Plan Letter 17-007 (Supersedes APL 15-001 and 13-013 revised) Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption
4. Welfare and Institutions Code §14185 (b)
5. All Plan Letter 18-006 (Supersedes APL 15-025 and 14-011 Interim Policy) Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder Health and Safety (H&S) Code §1373.96
6. All Plan Letter 11-019 Extended Continuity of Care for Seniors and Persons with Disability

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 for continuity of care.

2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Logs/Reports of the various continuity of care requests. Audits are performed on selected files to ensure compliance with the regulatory requirements.
        ii. Complaints and grievances for continuity of care are reviewed to identify problems and trends that will direct the development of corrective actions plans to improve performance.

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

3. Monthly Reports

a. Department of Health Care Services (DHCS)

The Alliance submits monthly reports for Continuity of Care following the submission process and format outlined in the DHCS All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data.

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POLICY AND PROCEDURE

Policy Number	UM-059
Policy Name	Continuity of Care for Medi-Cal Beneficiaries Who Transition into MediCal Managed Care
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL
Effective Date	5/3/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	5/17/2024
Administrative Oversight Committee Approval Date	7/17/2024

POLICY STATEMENT

All Alliance members, including Seniors and Persons with Disabilities, who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) or whose contracts are expiring/terminating to AAH as of January 1, 2023, with pre-existing provider relationships (medical or behavioral health,) may make a continuity of care request to the Alliance. For the 1/1/2024 transition of Alameda County to a Single Plan Model, AAH will ensure that continuity of care policies will protect Members access to care in accordance with the DHCS 2024 MCP Transition Policy Guide. Members may request up to 12 months of CoC with a Provider if a verifiable pre-existing relationship exists with that provider for any covered Medi-Cal service, with an out-of-network/nonparticipating Medi-Cal provider, when in the absence of continued services, would suffer serious detriment to health or be at risk of hospitalization or institutionalization. Members will have access to services consistent with the access they previously had.

1. Continuity of Care (CoC) protections extend to Primary Care Providers, Specialists and select ancillary providers as follows:

    a. Physical therapy
    b. Occupational therapy
    c. Speech therapy
    d. Respiratory therapy

e. Behavioral health
f. Durable medical equipment (DME)

2. The Alliance will provide continuity of care with an out-of-network (OON) provider when:

    a. The provider is providing a service that is eligible for Continuity of Care (CoC) for Providers.
    b. The Alliance is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider).
    c. An existing relationship means the member has seen an out-of-network primary care provider (PCP,) specialist, or behavioral health provider at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance for a non-emergency visit, unless otherwise specified in this policy or by state or federal law.
    d. If the Provider is an OON Provider, the Alliance will contact the Provider and make a good faith attempt to establish COC for the beneficiary.
    e. The Provider accepts the higher of the Alliance contract rates or Medi-Cal FFS rates.
    f. The Provider meets the Alliance's applicable professional standards and has no disqualifying quality of care issues.
        i. For the purpose of the DHCS All Plan Letter, a quality of care issue means The Alliance can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other Alliance members.
    g. The Provider is a California State Plan Approved Provider
    h. The Provider supplies the Alliance with relevant treatment information for the purposes of determining Medical Necessity, as well as a current treatment plan as allowable under applicable federal and state privacy laws and regulations.

3. During the 2024 Managed Care Transition to Single Plan Model, the following policies and procedures apply:
    a. For members identified as belonging to Special Populations, AAH will focus attention and resources on transitioning members to minimize the risk of harm from disruptions in their care:

        (a) Special Populations include:

            - Adults and children with authorizations to receive Enhanced Care Management (ECM) services
            - Adults and children with authorizations to receive Community Supports (CS).
            - Adults and children receiving Complex Care Management (CCM)
            - Enrolled in 1915(c) waiver programs
            - Receiving in-home supportive services (IHSS)
            - Children and youth enrolled in California Children's Services

(CCS)
- Children and youth receiving foster care, and former foster youth through age 25
- In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
- Taking immunosuppressive medications, immunomodulators, and biologics
- Receiving treatment for end-stage renal disease (ESRD)
- Living with an intellectual or developmental disability (I/DD) diagnosis
- Living with a dementia diagnosis
- In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
- Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
- Receiving specialty mental health services (adults, youth, and children)
- Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
- Receiving hospice care
- Receiving home health
- Residing in Skilled Nursing Facilities (SNF)
- Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
- Receiving hospital inpatient care
- Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
- Newly prescribed DME (within 30 days of January 1, 2024)
- Members receiving Community-Based Adult Services (CBAS)

b) The Previous MCP transitioning Members will transfer supportive information that is important to the incoming Members' care coordination and management.
c) AAH will work with the Previous MCP to transfer and share supportive information important for the Members' care coordination and management.
d) AAH will process CoC for provider requests and notify members according to the requirements of the DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide:
    - If a member's current provider is a network provider in both the Previous MCP and AAH, the member may continue to see their provider when the member transitions to AAH on 1/1/24. No action is required by the member to continue seeing their provider in this case.

- Some members who transition to AAH on January 1, 2024, will be receiving care from providers who are OON providers for AAH. If members wish to switch their care to an AAH network provider on January 1, 2024, AAH will facilitate that switch. For other members, transitioning to a new provider on January 1, 2024, may disrupt their care. CoC for Providers will enable transitioning members to continue receiving care from their existing providers for 12 months if certain requirements are met. This CoC for Providers protection is intended to maintain trusted member/provider relationships until the member can transition to a network provider with AAH. All transitioning members may request CoC for Providers with an eligible provider for up to 12 months.
    - Eligible Provider Types:
        - Primary Care Providers (PCP)
        - Specialists
        - Enhanced Care Management Providers
        - Community Supports Providers
        - Skilled Nursing Facilities (SNFs)
        - Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
        - Community-Based Adult Services Providers
        - Select ancillary Providers
            - Dialysis centers
            - Physical therapists
            - Occupational therapists
            - Respiratory therapists
            - Mental health Providers
            - Behavioral health treatment (BHT) Providers
            - Speech therapy Providers
            - Doulas
            - Community Health Workers
    - Ineligible Provider Types:
        - All other ancillary Providers, such as:
            - Radiology
            - Laboratory
            - Non-emergency medical transportation (NEMT)
            - Non-medical transportation (NMT)
            - Other ancillary services

- Non-enrolled Medi-Cal Providers

e) AAH will ensure that there is no disruption to the relationships between all transitioning members and their PCPs.
   - All transitioning members may request CoC for eligible providers for up to 12 months.
   - AAH will provide more than 12 months of CoC for Providers as needed for members living with a terminal illness, acute condition, or a pregnancy (including three trimesters of pregnancy, the immediate postpartum period, and 12 months following diagnosis of maternal mental health condition or end of pregnancy, whichever is later). The postpartum period is defined as 12 months
   - AAH will retain at least 90% of the transitioning members' PCPs either as network providers or through CoC for provider agreements. If AAH is unable to enter into a contract with a member's PCP, and the member requests to continue with their PCP, AAH will offer a Letter of Agreement (LOA) if all requirements are met. AAH will ensure that the members have the same PCP assignment as they had through their previous MCP, either through the providers' network participation or an LOA. Since the member is already included in the PCP's panel, a closed panel nor a status that the PCP is not accepting new members will affect the assignment of the member to their PCP. If a member wishes to change their PCP, they must notify AAH to assist with obtaining a new PCP.

f) For coordination of care and care transition efforts, AAH will adhere to the requirements of HCS 1373.96, and will allow non-contracted providers to continue a member's treatment plan for ineligible provider types that are delivering non-contracted services.

g) To access CoC for Providers, the member, Authorized Representative, or provider (i.e., the requester) must request CoC for Providers by contacting AAH. The requester may contact AAH prior to the date of service up until December 31, 2024.
   - If the services were rendered prior to the CoC request, the requester must contact AAH within 30 calendar days after the date of service. Upon receiving the request, AAH will confirm that the request meets the CoC requirements listed in section 2 above.

h) AAH will accept requests made over the telephone, electronically, or in writing, according to the requester's preference. AAH will ensure that transitioning members are able to access assistance from AAH's call center starting November 1, 2023, prior to their enrollment with AAH before January 1, 2024. AAH will confirm that the requirements in the DHCS Managed Care Plan Transition Policy Guide, section on CoC for Providers are met. If requirements are met, AAH will contact the eligible provider and make a good faith effort to either enter into a Network Provider Agreement with the eligible provider or enter into an LOA for the member's care and notify the provider and member. AAH will notify the member of the date the

request was received, whether the request was considered 'urgent,' 'immediate', or 'non-urgent' and why, and provide a statement of AAH's decision using the member's preferred form of communication or, if not known, by telephone call, text message, or email. The timeframe for processing requests and notifying the member and provider will be within the following timeframes appropriate to the member's condition:

Urgent	There is identified risk of harm to the member	As soon as possible, but no longer than 3 calendar days	Within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than 3 calendar days
Immediate	The member's medical condition requires more immediate attention, such as a provider appointment or other pressing services	15 calendar days	7 calendar days
Non-Urgent	The member's condition does not qualify for immediate or urgent status	30 calendar days	7 calendar days

- These timeframes apply to requests made prospectively. If the prospective request is made in advance of January 1, 2024, then AAH will complete processing the request by January 1, 2024, or according to these timeframes, whichever is later.
- Retroactive requests are not considered urgent or immediate.

4. AAH will ensure that transitioning members who seek assistance before January 1, 2024, while not yet enrolled in AAH are offered the same level of support they would receive on and after the January 1, 2024, enrollment date.

5. Provider Agreements

   a. When a CoC for Providers agreement is established, AAH will work with the eligible provider to ensure no disruption in services for the member.
   b. AAH will direct the eligible provider not to refer the member to other OON providers without prior approval from AAH.

c. After establishing a CoC for Providers agreement with the eligible provider, AAH will reimburse the provider for Covered Services for the appropriate duration in accordance with the Knox-Keene Act and the DHCS Medi-Cal Managed Care Plan Policy Guide, and as agreed upon with the provider.
d. As the end of the agreed-upon CoC period approaches, AAH will establish a process to transition the member to a network provider.
e. Sixty calendar days before the end of the CoC for Providers period, AAH will notify the member and the eligible provider about the process for transitioning the member's care.
f. AAH will identify a network provider, will engage the member, eligible provider, and the member's new network provider, and ensure the member's record is transferred within 60 days to ensure continuity of covered services through the transition to the network provider.
g. If AAH and the eligible provider are unable to reach an LOA, AAH will offer the member an alternative network provider in a timely manner, so the member's service is not disrupted.
h. If the member does not actively choose an alternative network provider, AAH will refer the member to a network provider
i. If there is no network provider to provide the Covered Service, AAH will arrange for an OON provider.

6. Enhanced CoC Protections for Special Populations:

a. Upon receiving data for Special Populations, AAH will proactively begin the Continuity of Care for Providers process
b. AAH will review all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding January 1, 2024, by January 1, 2024, or within 30 calendar days of receiving data for Special Populations, whichever is sooner.
c. AAH will contact identified eligible providers and negotiate a Network Provider Agreement or a CoC for Providers agreement if requirements in Section V.C of the 2024 MCP Transition Policy Guide are met.
d. AAH will notify the member and the member's Care Manager, when applicable, in accordance with the following requirements:
e. If the member's provider is in Network or is brought in Network as a result of AAH's outreach, then AAH will send notification that the member may continue with his or her provider.
f. If the member's provider is OON and AAH establishes an LOA, then AAH will notify the member that the length of time that they can stay with their provider.
g. If the provider is OON and cannot establish an LOA, AAH will send notification that the member must change to a network provider and assign the member a new network provider.
h. In all cases, the notification will include that the member may choose to change providers and comply with the notification requirements in DHCS 2024 MCP Transition Policy Guide Section V.C. Expectations of the Receiving MCP, and with the required timeline in Figure 6 of the DHCS 2024 MCP Transition Policy Guide

i. During the 6-month CoC for Services period, AAH will examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization and will contact those providers to establish any necessary Prior Authorizations.

7. Enhanced Protections for Members Accessing the Transplant Benefit

   a. If AAH is unable to bring a Transplant Program in Network, AAH will make a good faith effort to:
      1. Enter into a CoC for Providers agreement with the hospital at which a Transplant Program is located as described in the DHCS 2024 MCP Transition Policy Guide, section V.C and according to the following terms:
         i. Make explicit the existing statutory requirement that AAH will pay, and transplant providers are to accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code)
         ii. Permit the LOA agreement to continue for the duration of the member's access to the transplant benefit.
      2. If AAH is unable to enter into a CoC for Providers agreement, AAH will:
         i. Arrange for the hospital at which the Transplant Program is located to continue to deliver services to a member as an OON provider, in accordance with the timeline in Figure 6 of the DHCS Medi-Cal Managed Care Plan Transition Policy Guide:

	Timeframe for Processing CoC for Providers	Timeframe for Notifying Member After Processing CoC for Providers
Special Populations	30 calendar days from receipt of Special Populations data	7 calendar days

         ii. Explain in writing to DHCS why the provider and AAH could not execute an LOA.
   b. AAH will start reassessments for clinical necessity for members to continue accessing the transplant benefit no sooner than six months after the transition date (beginning July 1, 2024)
   c. AAH will ensure that members accessing the transplant benefit are provided services and/or treatments as expeditiously as possible.

8. Continuity of Care for Covered Services

   a. AAH will ensure that all transitioning members continue receiving Covered Services (Services) without seeking a new authorization from AAH during the 6-month CoC for Services period from January 1, 2024, to July 1, 2024.

b. AAH will honor active Prior Authorizations when data are received from the Previous MCP and/or when requested by the member, Authorized Representative, or provider and AAH obtains documentation of the Prior Authorization within the 6-month CoC for Services period. If the request is received before transitioning members are enrolled with AAH on January 1, 2024, AAH will be able to accept and process requests beginning November 1, 2023. Upon receipt of Prior Authorization data, AAH and the member will work together to continue the member's authorized service with a network provider if the member's provider is OON and does not enter a LOA. If the member needs to continue the service after 6 months, the provider will need to request a new authorization from AAH. AAH will allow members to continue an Active Course of Treatment without Prior Authorization for the 6-month CoC for Services period. AAH and the member will work together to continue the member's Active Course of Treatment with a network provider if the member's provider is OON and does not enter a LOA.
    i. An Active Course of Treatment is defined as a course of treatment in which a member is actively engaged with a provider prior to January 1, 2024, and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.
c. During the 6-month CoC for Services period, AAH will examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization and will contact those providers to establish any necessary Prior Authorizations.

9. AAH will allow members to keep their existing DME rentals and medical supplies from their existing DME providers without further authorization for 6 months after the 2024 MCP Transition and until reassessment, and the new equipment or supplies are in possession of the member and ready for use.
    a. This policy applies to DME or medical supplies that have been arranged for but not yet delivered, in which case AAH allows the delivery and permits the member to keep the equipment or supplies for a minimum of 6 months and until reassessment.
10. Transportation Benefits: Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
    a. If a network provider is not available to provide the transitioning member's scheduled NEMT/NMT service, then AAH will make a good faith effort to allow the transitioning member to keep the scheduled transportation service with an Out-of-Network (OON) NEMT/NMT provider.
    b. AAH will work with the Previous MCP to support continuation of NEMT/NMT services for transitioning members by the Previous MCP providing authorization data and transmitting all NEMT/NMT schedule data and Physician Certification Statement (PCS) forms to AAH on November 12, 2023, and refresh weekly starting in December 2023.
11. Continuity of Care and Management of Information during the transition to a Single Plan Model.
    a. The Previous MCP will transfer share supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans.

b. The Previous MCP will provide to AAH, by November 21, 2023, contact information for plan-level staff and for the Care Managers (program level contact information) who served transitioning members.

c. AAH will proactively contact the Previous MCP's point of contact(s) for Care Managers in order to obtain information to mitigate gaps in members' care.

d. The Previous MCP will share complete the transfer of supportive data for these members before January 1, 2024, or within 15 calendar days of the member changing to a new Care Manager, whichever is later.

e. AAH will receive the members known to be receiving inpatient care by December 22, 2023, from the Previous MCP, and will refresh that information daily through January 9, 2024, including holidays and weekends.
    i. Once a member is known to AAH as being in inpatient hospital care, either through the Previous MCP or via other means, AAH will contact the hospital to provide for completion of and coordination of the member's care. AAH will also contact the inpatient member's Primary Care physician responsible for the patient's care while they are admitted.

f. AAH will obtain confirmation from the Previous MCP to ensure that they completed all data transfer sharing activities as described below in the Continuity of Care Data Sharing Policy:
    i. The Previous MCP will transmit DHCS required utilization data, authorization data, member information, including preferred form of communication, supplemental accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to AAH.

12. Acceptance of requests may be from the Member, authorized representative, or Provider. The Alliance will not require the requester to complete and submit a paper or online form if the requester prefers to make the request by phone, electronically or in writing, according to their preference. To complete a telephone, electronic or written request, the Alliance will take any necessary information required to complete the request using the members' preferred method.

4. Retroactive Continuity of Care

a. Members are able to receive retroactive continuity of care – meaning they can see their prior provider(s) while the Alliance processes a continuity of care request. All continuity of care requirements continue to apply, including a validated pre-existing relationship between the member and provider. The Alliance will retroactively approve and reimburse providers for continuity of care for services that were already rendered if requirements are met.
b. The member, authorized representative, or provider submitting the continuity of care request must submit the request within 30 calendar days of the first service provided after the member joins the Alliance. The provider can continue to treat

the member for those 30 days and will be reimbursed if all continuity of care requirements are met.

c. Once the Alliance and provider have agreed to terms, the provider must agree to follow the Alliance's utilization management requirements.

5. Validating Pre-existing Relationship

The Alliance will determine if a relationship exists through use of data provided by DHCS to the Alliance, such as Medi-Cal FFS utilization data. A member or his or her provider may also provide information to the Alliance that demonstrates a pre-existing relationship with the provider. A member's self-attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless the Alliance makes this option available to the member.

6. Acknowledgment of CoC request

The acknowledgement will advise the member that the CoC request has been received, the date of receipt and the estimated timeframe for resolution. Communication will be done using the Member's know preference of communication or by telephone or mail within the following timeframes:

- For non-urgent requests, within seven calendar days of the decision.
- For urgent requests, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three calendar days of the decision

7. Request Completion Timeline

Continuity of care begins when the Alliance receives the CoC request. The Alliance will determine if the member has a pre-existing relationship with the provider, the provider is willing to accept the Alliance contract rates or Medi-Cal FFS rates, has no disqualifying quality of care issues and is a CA State Plan approved provider.

a. Each continuity of care request are completed within the following timelines: (all decisions will be communicated to the member by mail)

i. Thirty calendar days from the date AAH received the request for non-urgent requests.

ii. Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs: or,

iii. Three calendar days for urgent requests if there is risk of harm to the member.

b. A continuity of care request is considered completed when:

i. The member is informed of his or her right of continued access.

ii. The Alliance and the out-of-network FFS or prior MCP provider are unable to agree to a rate;

iii. The Alliance has documented quality of care issues; or

iv. The Alliance makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

8. Requirements after the Request Process is Completed.

i. If the Alliance and the out-of-network Medi-Cal FFS provider are unable to reach an agreement because they cannot agree to a rate, or the Alliance has documented quality of care issues with the provider, the Alliance will offer the member an in-network alternative.

ii. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to file a grievance.

iii. If a provider meets all of the necessary requirements, including entering into a Letter of Agreement or contract with the Alliance, the Alliance will allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with Alliance for a shorter timeframe. In this case, the Alliance allows the member to have access to that provider for the shorter period of time.

iv. At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the Alliance works with the provider to establish a care plan for the member.

v. Upon approval of a continuity of care request, the Alliance notifies the member by mail of the following within seven calendar days and no more than 3 calendar days for urgent requests:
   - The duration of the continuity of care arrangement.
   - The process that will occur to transition the member's care at the end of the continuity of care period.
   - The member's right to choose a different provider from the Alliance's provider network.

vi. Upon denial for CoC services the Alliance will notify the member by mail and provider by fax within seven (7) days with:
   - A statement of the denial decision.
   - A clear and concise explanation for the reasons for denial.
   - Rights and responsibilities to file a grievance and/or appeal.

vii. The Alliance notifies the member 60 calendar days before the end of the continuity of care period, using the member's preferred method of communication, about the process that will occur to transition the member's care to an in-network provider at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

viii. if the member does not continue services from their pre-existing provider the Alliance will arrange for CoC covered services without delay with an in-network provider or if there is no network provider with an OON provider.

9. The Alliance's Extended Continuity of Care Option: The Alliance may choose to work with the member's out-of-network provider past the 12-month continuity of care period, but the Alliance is not required to do so to fulfill its obligations under state contractual requirements. Extended CoC will be provided to following Special Populations:

Special Population	Duration
Receiving Hospice Care	For the duration of the terminal illness
Pregnancy or Postpartum	Within 12 months of pregnancy completion or maternal mental health diagnosis
Receiving hospital inpatient care	For the duration of the acute condition

10. Member and Provider Outreach and Education

a. The Alliance will inform members of their continuity of care protections and includes information about these protections in member information packets and handbooks and on the Alliance website. This information includes how the member and provider initiate a continuity of care request with the Alliance. The Alliance will translate these documents into threshold languages and make them available in alternative formats, upon request. The Alliance provides training to call center and other staff who come into regular contact with members about continuity of care protections.

b. Provider Referral Outside of the Alliance's Network
   i. An approved out-of-network provider must work with the Alliance and its contracted network and must not refer the member to another out-of-network provider without authorization from the Alliance. In such cases, the Alliance will make the referral, if medically necessary, and if the Alliance does not have an appropriate provider within its network.
   ii. The Alliance will work with the approved OON provider and communicate its requirements on letters of agreement, referral, and authorization processes.

11. Medi-Cal FFS to Managed Care Transition:

a. The Alliance will use treatment authorization requests (TAR)data or prior authorization (PA) data to identify PA authorizations, including authorized procedures, surgeries, DME, medical supplies, OP rehab, respiratory therapy, or behavioral health
b. Active prior treatment authorizations for services remain in effect for 90 days and will be honored by the Alliance without a request by the member, authorized representative, or provider;

c. The Alliance will arrange for services authorized under the active prior treatment authorization with a network provider, or if there is no network provider to provide the service, with an OON provider;
d. After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by an Alliance network provider, whichever is shorter;
e. If the Alliance does not complete a new assessment, the active treatment authorization remains in effect and after 90 days
f. the Alliance may reassess the member's prior treatment authorization at any time
g. A new assessment is considered complete if the Member has been seen in person and/or via synchronous telehealth by a network provider and the provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization
h. Where a service has been rendered with an OON provider and that provider satisfies the CoC requirements, the Member, authorized representative, or provider may request CoC retroactively to cover the service. (see #4)
i. If reassessing Enhanced Care Management (ECM) authorizations after 90 days, the Alliance will reassess against ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria. The Alliance will provide continuity of care with an out-of-network provider for FFS members who voluntarily transition to the Alliance to receive Enhanced Care Management (ECM) services.

12. Mental Health Plan Transition into Medi-Cal Managed Care:

a. The Alliance covers required outpatient mental health services for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition, as defined by the current Diagnostic and Statistical Manual. County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for beneficiaries who meet the medical necessity criteria for SMHS.

b. A member can request continuity of care with an out-of-network SMHS provider in instances where the member's mental health condition has stabilized such that the member no longer qualifies for SMHS and the responsibility for the member's mental health services transitions from the MHP to Alameda Alliance for Non-Specialty Mental Health Services (NSMHS). CoC only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medi-Cal State Plan, to provide NSMHS. The Alliance will allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network MHP provider in accordance with the requirements mandated by the state. After 12 months the member must choose a mental health provider in the Alliance network for NSMHS. If the member later requires additional specialty mental services, the 12-month CoC period may start over one time. If the Member requires SMHS from the MHP subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to the AAH or changes MCPs (i.e., the Member does not have the right to a new 12 months of Continuity of Care).

13. Behavioral Health Treatment for Members Under the Age of 21 Upon Transition:

    a. The Alliance is responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.

    b. In accordance with existing contract requirements for Behavioral Health Treatment Coverage for Members Under the Age of 21, the Alliance will offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all requirements in this policy are met.

    c. For BHT, an existing relationship means a member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from a Regional Center (RC) to AAH or the date of the member's initial enrollment AAH if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, the Alliance will assign the member to that provider to continue BHT services.

    d. Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into the Alliance, or the date of the member's enrollment into the Alliance, if the enrollment date occurred after the transition.

    e. The Alliance will continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

14. Transition of BHT Services from Regional Centers (RCs) to Alameda Alliance

    a. At least 45 days prior to the transition date, DHCS will provide the plan with a list of members for whom the responsibility for BHT services will transition from RCs to the Alliance, as well as member-specific utilization data.

    b. The Alliance considers every member transitioning from an RC as an automatic continuity of care request. DHCS will also provide the Alliance with member utilization and assessment data from the RC prior to the service transition date. AAH uses the DHCS-supplied utilization data to identify each member's BHT provider(s) and proactively contact the provider(s) to begin the continuity of care process, regardless of whether a member's parent or guardian files a request for continuity of care.

    c. If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, the Alliance will attempt to contact the member's parent or guardian to determine their preference. If the Alliance does not have access to member data that identifies an existing BHT provider, the Alliance will contact the member's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist the Alliance in offering continuity of care.

d. If the RC is unwilling to release specific provider rate information, then the Alliance may negotiate rates with the continuity of care provider without being bound by the usual requirement that the Alliance offer at least a minimum FFS-equivalent rate. If the Alliance is unable to complete a continuity of care agreement, the Alliance ensures that all ongoing services continue at the same level with an Alliance in-network provider until the Alliance has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.

e. AAH uses the Continuity of Care section of APL 18-006 for additional requirements and information regarding continuity of care for transitioning members receiving BHT.

15. Existing Continuity of Care Provisions Under California State Law:

a. In addition to the protections set forth above, the Alliance members also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with Welfare and Institutions Code Section (§) 14185(b), the Alliance will allow members to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by the Alliance, until the prescribed therapy is no longer prescribed by the Alliance-contracting provider.

Additional requirements pertaining to continuity of care are set forth in Health and Safety Code (HSC) §1373.96 and require the Alliance to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under HSC §1373.96, health plans are required to complete services for the following conditions: acute (for the duration of the condition), serious chronic (for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider up to 12 months), pregnancy (all trimesters, delivery and 12 months post- partum), terminal illness (for the duration of the terminal illness which may exceed 12 months), the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by the health plan as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member.

To maintain compliance with the law, the Alliance allows for completion of covered services as required by HSC §1373.96, to the extent that doing so allows member a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this policy. The Alliance allows for the completion of these services for certain timeframes which are specific to each condition and defined under HSC §1373.96.

16. Pregnant and Post-Partum Beneficiaries:

As required by law (reference: HSC §1373.96) the Alliance will, at the request of a member, provide for the completion of covered services relating to pregnancy, during pregnancy and the post-partum period (which is 12 months) and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan provider. This process will apply for pregnant and post-partum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to HSC §1373.96 for additional information about applicable circumstances and requirements.

The Alliance allows Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into the Alliance the right to request out-of-network provider continuity of care for up to 12 months in accordance with the Alliance's contract and the general requirements. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of this policy (continuity of care for members transitioning from FFS to managed care).

17. Medical Exemption requests (MER):

    a. A Medical Exemption Request is a request for temporary exemption from enrollment into a MediCal Managed Care Plan (MCP) only until the Member's medical condition has stabilized to a level that would enable the Member to transfer to an AAH provider of the same specialty without deleterious medical effects.
    b. A MER only applies to Members transitioning from Medi-Cal FFS to AAH.
    c. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under these circumstances.
    d. AAH is only required to consider MERs that have been denied as an automatic continuity of care request to allow to the Member to complete a course of treatment with a Medi-Cal FFS provider
    e. The Alliance considers MERs that have been denied as an automatic continuity of care request to allow the member to complete a course of treatment with a Medi-Cal FFS provider.

18. Covered California Medi-Cal Transitioning members:

    a. This section specifies provisions for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year.

    b. To ensure that continuity of care and coordination of care requirements are met, the Alliance asks these members if there are upcoming health care appointments or treatments scheduled and assist them. If the member requests CoC, the Alliance will help in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights.

c. When a new member enrolls in the Alliance, the Alliance contacts the member by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this section are included in this initial member contact process.

d. The Alliance will make a good faith effort to learn from and obtain information from the Member so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

e. The Alliance will honor any active prior treatment authorizations for up to 90 days After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by AAH, whichever is shorter. FFA new assessment is considered completed by the Alliance if the member has been seen by an Alliance contracted provider, (in person and/or via synchronous Telehealth,) and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations are honored without a request by the member or the provider

f. The Alliance will, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with the requirements in this policy.

19. When the Alliance and the OON treating provider are unable to reach an agreement with the terminated or OON provider because they cannot agree to a rate or if the member, authorized representative, or provider does not submit a request for the completion of covered services by said provider, the Alliance is not required to continue the provider's services. If the Alliance has documented quality of care issues with the provider, the Alliance will offer an in-network alternative.

    a. If the Member does not make a choice, the Member will be referred or assigned to an in-network provider.
    b. If the Member disagrees with the result of the CoC process, the Member maintains the right to pursue a grievance and/or appeal.

20. DME equipment rentals and medical supplies will be honored without a request by a member or provider. If the DME or medical supplies have been arranged, but the equipment or supplies shave not been delivered, the Alliance will allow for the delivery of the equipment and supplies for a minimum of 90 days following enrollment until the Alliance can complete a new assessment. The original authorization will remain in effect for the duration of the treatment authorization. After 90 days, the Alliance may reassess at any time and move the member to a network DME provider.

21. For Non-emergency medical (NEMT) and non-medical (NMT) transportation services the member will be allowed to keep the modality of transportation under their previous prior authorization with a network provider until a new assessment can be made.

22. For Enhanced Care Management (ECM) authorizations after 90 days are reassessed using the ECM discontinuation criteria and not the ECM population of focus eligibility criteria.

23. 12-Month continuity of Care Period Restart
    a. if a member changes MCPs by choice following the initial enrollment or if a member loses and then later eligibility during the 12-month CoC period, the 12-month CoC for a pre-existing provider may start over one time. For example, if a member enrolls in on 1/1/23, but then changes to a different MCP by choice on 5/1/23, the CoC may start over one time and the member may see that provider until May of the following year.
    b. If a beneficiary changes their Medi-Cal MCP a second time or more, the COC period does not start over. The beneficiary does not have the right to a new COC 12-month period. If the beneficiary returns to Medi-Cal FFS and later reenrolls in a Medi-Cal MCP, the COC period does not start over. If the member changes their Medi-Cal MCP, this COC policy does not extend to Providers they utilized under their other managed care plan.

24. Scheduled Specialty Appointments
    a. the Alliance will allow transitioning members to keep authorized and scheduled specialist appointments with OON providers when CoC has been established and the appointments occur during the 12-month CoC period.
    b. if a member or provider requests to keep scheduled specialist appointments with an OON provider and the member has not seen the provider in the previous 12 months and there is no established relationship with the OON provider, the Alliance make a good faith effort to arrange for the member to keep the appointment with a network provider on or before the appointment with the OON provider. If the Alliance is unable to do so, since the appointment is after transitioning to the Alliance and there is no pre-existing relationship, CoC would not apply.

25. Delegates are required to comply with all applicable state and federal laws and regulations, contract requirements and other DHCS guidance, including All Plan Letters.

PROCEDURE

1. Initiation of non-MER request:

    a. Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to the Alliance for continuity of care.

    b. When this occurs, the Alliance begins to process the request within five working days following the receipt of the request, however, the request is completed in three calendar days if there is a risk of harm to the member. For the purposes of this policy, "risk of harm" is defined as an imminent and serious threat to the health of the member.

    c. The continuity of care process begins when the Alliance starts the process to determine if the member has a pre-existing relationship with the provider.

d. The UM Coordinator receives request for CoC through the HealthSuite Service Request, facsimile, or telephone call from provider.

    1 The Alliance accepts requests for continuity of care over the telephone, according to the requester's preference, and does not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, the Alliance may take any necessary information from the requester over the telephone.

e. The UM Coordinator verifies eligibility and product line, creates a shell authorization request in the Clinical Information System (TruCare), selects indicator for non-MER CoC and routes request to appropriate UM Clinical Specialist.

f. The UM Clinical Specialist reviews the request, contacts the Member or Provider for any additional information to determine the type of CoC service required and document existence of an existing relationship.

    1 Existing relationships can be validated through data provided by DHCS to The Alliance, such as Medi-Cal FFS utilization data.

    2 A Member or his or her provider may also provide information demonstrating a pre-existing relationship with a provider.

    3 A Member may not attest to a pre-existing relationship; actual documentation must be provided.

g. The UM Clinical Specialist obtains all necessary information to assist in making the initial determination, i.e., medical records, eligibility segments, claims.

h. The UM Clinical Specialist documents determination in authorization requests.

    1 Approvals – UM Clinical Specialist contacts Member to inform them of the approval determination and next step. The UM Clinical Specialist:

        1. Contacts requested provider to ensure they will see member and provides the "statement of reimbursement."

        2. Reviews applicable websites to verify Provider does not have any quality of care restrictions.

        3. Notifies Provider Relations (PR) to begin Letter of Agreement process, initiates PR communications.

4. Once approved by all parties, UM Clinical Specialist completes authorization request, generates, and sends Approval Notification to Member, Provider, assigned PCP and assigned Provider Group.

2 For potential denials based on request not meeting service criteria or Provider refusing to see Member or accept rates, the UM Clinical Specialist routes case to the UM Medical Director/doctoral Behavioral Health Practitioner with all of the information documented in TruCare authorization requests.

i. The UM Medical Director/ doctoral Behavioral Health Practitioner will review all available information and make a final determination.

1 If determination is to approve, the UM Medical Director/doctoral Behavioral Health Practitioner documents review in TruCare authorization notes section and routes to UM Clinical Specialist to complete communications. Documentation should include the type of CoC applicable to case and why services are met.

2 If determination is to deny, the UM Medical Director/doctoral Behavioral Health Practitioner documents review in TruCare authorization notes section and routes to UM Clinical Specialist to complete Member communications. Documentation should include:

1. type of CoC applicable, why services are not met and the applicable denial reason; documents the applicable denial reason in the authorization request.

2. confirmation that the services can be provided in-network and communication with PCP to obtain the necessary services and authorizations.

j. Development of Plan of Care

1 The Alliance UM Department UM staff or Behavioral Health staff as appropriate will coordinate with OON Provider to obtain a copy of the plan of care during the OON service. The Plan of Care will be shared with the assigned PCP and/or Provider Group to ensure all services necessary to manage the identified treatment plan are in place or arranged.

k. Transition to In-Network Services

1 The Member may change their provider to an in-network provider at any time regardless of whether or not the CoC relationship has been established.

2 For approved CoC, Members will be informed of the approved services, frequency, and duration for services with the OON provider.

1. The Alliance will monitor open existing authorizations with OON providers by the identified UM report.

2. One month prior to the expiration of the OON authorization, the UM and CM/BH Departments will coordinate with the Provider and the Member to begin transitioning back services to the in-network provider.

3 When the Alliance and the OON treating provider are unable to reach an agreement because they cannot agree to a rate or the Alliance has documented quality of care issues with the provider, the Alliance will coordinate with the PCP or assigned Provider Group to identify an in-network alternative.

1. If the Member does not make a choice, the Member will be referred or assigned to an in-network provider.

2. If the Member disagrees with the result of the CoC process, the Member maintains the right to pursue a grievance and/or appeal.

l. The Alliance submits reports related to any Continuity of Care provisions outlined in state law and regulations, or other state guidance documents.

m. Delegation

1 For services that are the responsibility of the delegate, the UM Clinical Specialist will facilitate and coordinate with the assigned delegate CoC contact. The UM Clinical Specialist documents in the TruCare authorization request the name and phone number of the delegate contact, and the PG outcome. The authorization request determination is documented as a "deny – responsibility of PPG" and case is closed.

Delegates are required to process the CoC request as defined by policy or regulation.

DEFINITIONS / ACRONYMS

Medical Exemption Request (MER) means a request for temporary exemption from enrollment into a managed care plan (MCP) only until the member's medical condition has stabilized to a level that would enable the member to transfer to an MCP provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to members transitioning from Medi-Cal FFS to a managed care plan. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above.

Applied Behavioral Treatment (ABA): means services provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider.

Authorized Representative: means a person other than the plan member who is authorized to receive confidential information related to the member, and who may speak on the member's behalf.

Autism Spectrum Disorder (ASD): means a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome. These conditions are now all called ASD.

Behavioral Health Treatment (BHT): means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.

California State Plan: In response to the CMS guidance and in accordance with Title 42 Code of Federal Regulations Section 440.130©, the Department of Health Care Services (DHCS) issued interim guidance on September 15, 2014 in APL 14-011 to include BHT services as a covered Medi-Cal benefit for beneficiaries under 21 years of age when medically necessary, based upon recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of ASD to the extent required by the federal government.2 BHT services, such as Applied Behavior Analysis (ABA) and other evidence-based interventions, professional services, and treatment programs, prevent or minimize the adverse effects of ASD, and promote, to the maximum extent practicable, the functioning of a beneficiary with ASD.

Continuity of Care (COC): means a process for ensuring that care is delivered seamlessly across a multitude of delivery sites and transition in care throughout the course of the disease.

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

Durable Medical Equipment (DME): means any medical equipment necessary to use in the home to aid a better quality of living.

Early, Periodic Screening, Diagnosis, and Treatment Services (EPSDT): means the federal program requiring states to provide screening, preventive, and medically necessary diagnostic and treatment services, to members of Medicaid Managed Care Programs.

Fee-for-Service (FFS): means a method of payment based upon per unit or per procedure billing for services rendered to an eligible beneficiary.

Managed Care Provider (MCP): means a participating provider or a contracted provider in a Medi-Cal Managed Care Health Plan.

Medically Necessary or Medical Necessity: Those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical practitioner, exercising prudent clinical judgment, would provide to a member for the purpose of

preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

1. Consistent with nationally accepted standards of medical practice:

    a. "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.
    b. For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
    c. For purposes of covered services for Medi-Cal members, the term "medically necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and
    d. When determining the medical necessity of Covered Services for a Medi-Cal member under the age of 2, "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.

2. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), the Alliance will apply the definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards as follows:

    a. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body enrollee, or otherwise medically necessary under 42 CFR §1395y.
    b. For Medi-Cal services: reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under Title 22 California Code of Regulations (CCR) Section 51303.

Members: Any eligible beneficiary who is enrolled in any of the Alliance's product lines of business.

Out of Network (OON): means a non-participating provider or a non-contracted provider in a Medi-Cal Managed Care Health Plan.

Primary Care Provider (PCP): means a primary care physician or clinic responsible for coordinating, supervising, and providing primary health care services to a member, including but not limited to initiating specialty care referrals and maintaining continuity of care.

Provider: means primary care physicians, specialists, ancillary providers, clinics, and hospitals.

Quality of Care Issue (DHCS definition) means The Alliance can document its concerns with the Provider's quality of care to the extent that the Provider would not be eligible to provide services to any other Alliance members.

Risk of Harm is defined as an imminent and serious threat to the health of the member.

Seniors and People with Disabilities (SPD): means person(s) 65 years or older and/or individual(s) meeting one of the following criteria: he or she has a physical or mental impairment that substantially limits one or more of his/her major life activities; he or she has a record of such an impairment; he or she is regarded as having such an impairment.

Treatment Authorization Request (TAR): means a referral or request for services. Services may be initial or ongoing.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Member Services
Provider Relations
Compliance

RELATED POLICIES AND PROCEDURES

- UM-036, "Cont. Covered Services for Members with Terminated Providers"
- UM-058, "COC for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption".
- UM-002 Behavioral Health Services

REVISION HISTORY

5/3/2018, 4/19/2019, 5/21/2020, 3/18/2021, 3/22/2022, 06/20/2023, 12/19/2023, 7/17/2024

REFERENCES

- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- APL 17-007 (Supersedes APL 15-001 and 13-013 revised) Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption
- APL 20-017 Requirements for Reporting Managed Care Program Data (Supersedes APLs 14-013 (Revised) and 14-012)
- APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 22-018)
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (Supersedes APL 19-014)
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.

(Supersedes All Plan Letters 22-032, 18-008, 15-019, 14-021 and 13-023)

- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- Duals Plan Letter 15-003 Continuity of Care
- Health and Safety (H&S) Code §1373.96, 1371.8, 1373.65, 1373.95
- Welfare and Institutions Code §14185

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 for continuity of care.
2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Logs/Reports of the various continuity of care requests. Quarterly audits are performed on selected files to ensure compliance with the regulatory requirements.
    b. Complaints and grievances for continuity of care are reviewed to identify problems and trends that will direct the development of corrective actions plans to improve performance.
    c. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.

3. Monthly Reports
    a. Department of Health Care Services (DHCS)

The Alliance submits monthly reports for Continuity of Care following the submission process and format outlined in the DHCS All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data.

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POLICY AND PROCEDURE

Policy Number	UM – 060
Policy Name	Delegation of Utilization Management
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Line(s) of Business	MCAL, IHSS
Effective Date	06/16/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/16/2024
Compliance Committee Approval Date	3/19/2024

POLICY STATEMENT

The Alliance is responsible for the oversight of delegated Utilization Management (UM) responsibilities. The Alliance ensures the delegate has a systematic and effective Quality Management (QM)/UM program for providing access to quality healthcare services to the Alliance members, consistent with regulatory and contractual standards. Delegated entities are required to have certain Utilization Management components and functions in adherence to DHCS, DMHC, and the Alliance standards to ensure the member's experience and outcomes are front and center. 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 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 QM/UM responsibilities for the delegated entity and the Alliance. Delegates are required to use Alliance approved UM clinical criteria guidelines when performing delegated UM functions on behalf of the Alliance through the delegate agreement, consistent with the AAH approved UM hierarchy of evidenced medical necessity criteria. Criteria guidelines requested to be used by delegates that are different from the Alliance guidelines are reviewed and considered for approval annually at the AAH UM Committee.

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

The Alliance Compliance Delegation Oversight Unit is responsible for the management and coordination of delegated activities. The Compliance Department collaborates with each internal department responsible for the delegated activities to identify staff responsible for being the subject matter expert and coordinate auditing and oversight functions.

PROCEDURE

A. The Alliance will establish a mutually agreed upon delegation agreement with the delegated entity to include UM responsibilities and reporting activities of the delegate, the oversight and monitoring responsibilities and process of the Alliance. It also 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.

B. 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 on whether the areas are applicable to the delegate's contracted responsibilities, annually through the delegation oversight audit, to potentially include but not limited to:

1. Utilization Management (UM) program
2. UM policies and procedures
   a) Including but not limited to inpatient hospital services, outpatient care, Long Term Care, referral program, prior authorization process, over/underutilization, coordination of care, medical records, and mental health services/substance abuse services, if applicable
3. UM committee meeting minutes
4. Authorization case file review, approvals, and denials
5. Out of Plan/Linked and Carve Out Services, e.g. California Children Services (CCS), Early Intervention/Early Start (EPSDT) , Developmental Disability Services (DDS),
6. Initial Health Assessments
7. For Long Term Care:
   - Bed Holds, Leave of Absences, Required timelines for Physician oversight
8. Delegation activity reporting
9. Follow-up of any issues found within the last year's delegation reporting and previous audit(s).

C. Through the annual delegation oversight audit, the Alliance will review the delegated activities and score or assess 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 act on this situation and issue a written corrective action plan and recommendations for improvement to the delegate. The Alliance will evaluate whether deficiencies were corrected, and follow-up on the actions until all are resolved. The delegation audits will review past findings to ensure policies and procedures changes have been effective and evaluate if there are any repeated findings.

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

E. On an annual basis, clinical criteria/guidelines requested to be used by delegates are brought to the Utilization Management Committee for review and potential approval. Delegates may use the approved clinical guidelines. If not approved, the delegate may not use the clinical guidelines.

F. Delegates are required to report UM performance data to the Alliance on an established frequency, e.g., monthly, quarterly, semi-annually and/or annual basis. For UM activities, delegate reports are reviewed by the Alliance UM department to ensure compliance standards are being met.

G. Delegates are required to submit monthly reports in the format of performance data for outpatient and inpatient services. The Alliance has adopted the Health Industry Collaboration Efforts (HICE) UM Reporting Templates. The templates are released annually by HICE and made available to delegates. Delegates are also permitted to submit performance data in a mutually agreed upon format as needed for data that does not conform to the HICE template.

Oversight reports are submitted to the Alliance Compliance Department and routed to the UM Department for review by the Oversight Staff or UM Management. The reports will include a review of the data to the delegate's performance and the Alliance benchmarks and goals. The Alliance UM staff will provide written feedback to the delegate on the timeliness of the delegate's reporting, performance against the benchmark and identify any opportunities for improvement. Opportunities for improvement identified during the review require a formal corrective action plan and will be monitored for improvement toward the goals.

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

1. Member Experience data, e.g. CAHPS, related to UM. On an annual basis, UM staff will provide the results of the member experience data related UM to identify and address opportunities to improve the UM system. Delegates may be included in work-plans to address identified issues or in various workgroups developed to address opportunities that impact multiple delegates.
2. Clinical performance data, e.g. HEDIS measures, ambulatory utilization, hospital utilization, complex case management. On a quarterly basis, the UM staff will review and provide delegate specific performance measures

I. Any cited deficiencies cited by the Department are communicated to the Delegate through a written Corrective Action Plan (CAP) as defined in *CMP-020 Corrective Action Plan.*

J. Delegation reports are reviewed by the Compliance Committee and forwarded to HCQC committee for review. All delegation oversight activities are reported to the HCQC committee for review and recommendations.

K. 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

None

AFFECTED DEPARTMENTS / PARTIES

Complaints and Resolutions
Compliance
Credentialing
Member Services
Quality Improvement
Utilization Management

RELATED POLICIES AND PROCEDURES

QI-111 Delegation of Management and Oversight
CMP-019 Delegation Oversight
CMP-020 Corrective Action Plan

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

6/16/2016, 3/1/2018, 7/19/2018, 11/21/2019, 3/18/2021, 3/22/2022, 02/21/2023, 3/19/2024

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, Delegation of UM

MONITORING

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

POLICY AND PROCEDURE

Policy Number	UM-063
Policy Name	Gender Affirming Surgery and Services
Department Name	Health Care Services
Policy Owner	Director of Utilization Management
Line(s) of Business	MCAL, IHSS
Effective Date	11/21/2013
Subcommittee Name	Quality Improvement Health Equity Committee (QIHEC)
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

Alameda Alliance for Health (the "Alliance") covers gender affirming medically necessary care for transgender and gender diverse members, consistent with the World Professional Association of Transgender Health (WPATH) Standard of Care for Transgender and Gender Nonconforming People for Group Care and Medi-Cal. Gender affirming medically necessary care for Medi-Cal members is consistent with DHCS **APL 20-018**.

1. The Alliance provides medically necessary covered services to all Medi-Cal beneficiaries and Group Care enrollees, including transgender diverse (TGD) beneficiaries Gender diverse people includes but is not exhaustive to include non-binary, eunuch, and intersex individuals.
2. Medically necessary covered services are those services:
   a. Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. **(Title 22 California Code of Regulations §51303).**
   b. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. **(Welfare and Institutions Code section 14059.5.)**
   c. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. **(Title 42 USC 1396d(r)(5)).**
   d. "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms,

including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

i. In accordance with the current generally accepted standards of mental health and substance use disorder care.

ii. Clinically appropriate in terms of type, frequency, extent, site, and duration.

iii. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provide **(Health and Safety Code section 1374.72 (3) (A)).**

3. The Alliance considers the following treatment medically necessary for all Members with gender dysphoria/gender incongruence:
   a. Mental health services, including psychotherapy;
   b. Gender affirming (GA) feminizing/masculinizing hormone therapy and/or puberty blocker/ hormone therapy with clinical monitoring for efficacy and adverse events;
   c. GA surgery that is not strictly cosmetic in nature but addresses gender dysphoria/incongruence and/ or reconstructive services.
4. The Alliance must provide medically necessary reconstructive surgery to all Medi-Cal beneficiaries, including TGD beneficiaries. Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) to improve function. (B) to create a normal appearance, to the extent possible" **(Health and Safety Code § 1367.63 (c) (1) (A) (B)).**
5. In analyzing GA medical and surgical service requests, the Alliance must analyze GA requests under both the applicable medical necessity standard for services to treat gender dysphoria/incongruence and under the statutory criteria for reconstructive surgery. A finding of either "medically necessary to treat gender dysphoria" or "meets the statutory criteria of reconstructive surgery" serves as a separate basis for approving the request.
6. If the Alliance determines that the service is medically necessary to treat the member's gender dysphoria/incongruence, the Alliance must approve the requested service. If the Alliance determines the service is not medically necessary to treat gender dysphoria/incongruence (or if there is insufficient information to establish medical necessity), the Alliance must still consider whether the requested service meets the criteria for reconstructive surgery, taking into consideration the gender with which the member identifies.
7. The request for transgender services should be supported by evidence of either medical necessity or evidence supporting the criteria for reconstructive surgery. Supporting documentation should be submitted, as appropriate, by the member's primary care provider ("PCP"), licensed mental health professional, and/or surgeon. These providers should be qualified and have experience in transgender health care.
8. The Alliance will cover medically necessary medications to treat gender dysphoria/incongruence, mental health or substance use disorders.
9. The Alliance is required to treat beneficiaries consistent with their gender identity **(Title 42 United States Code §18116; see also 45 CFR § 156.125).**
10. Federal regulations prohibit the Alliance from denying or limiting coverage of any health care services that are ordinarily or exclusively available to beneficiaries of one gender, to a TGD beneficiary based on the fact that a beneficiary's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available **(45 CFR §§92.206, 92.207 (b) (3)).**

11. DHCS indicates that Federal regulations further prohibits the Alliance from categorically excluding or limiting coverage for health care services related to gender transition **(DHCS APL 20-018).**
12. The Insurance Gender Nondiscrimination Act ("IGNA") prohibits the Alliance from discriminating against individuals based on gender, including gender identity or gender expression **(Health and Safety Code section § 1365.5).** The IGNA requires that the Alliance provide transgender beneficiaries with the same level of health care benefits available to non-transgender beneficiaries.
13. The Alliance may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive surgery determination, and/or apply appropriate utilization management criteria that are non-discriminatory. The Alliance may not categorically exclude health care services related to gender transition on the basis that it excludes those services for all members.
14. The Alliance must not categorically limit a service or the frequency of services available to a TGD member. For example, classifying certain services, such as facial feminization surgery as always "cosmetic" or "not medically necessary for any Medi-Cal member" is an impermissible "categorical exclusion" of the service. The Alliance must consider each requested service on a case-by-case basis and determine whether the requested service is either "medically necessary to treat the member's gender dysphoria" or meets the statutory definition of "reconstructive surgery."
15. In the case of TGD beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies (target gender).
16. Medi-Cal is not required to cover cosmetic surgery. Cosmetic surgery is "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance" **(Health and Safety Code § 1367.63(d))** or self-esteem. However, if the service request is reconstructive in nature to improve function, and/ or for the alleviation or treatment of gender dysphoria/incongruence then it would be medically necessary.

PROCEDURE

Gender dysphoria (defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5) is treated with the following core services:

- Behavioral health services;
- Psychotherapy;
- GA feminizing/ masculinizing hormone and/or puberty blocker/ hormone therapy with clinical monitoring for efficacy and adverse events;
- Surgical and GA procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender, which is not strictly cosmetic in nature. Sex reassignment surgery (also known as GA surgery), is a treatment option for TGD beneficiaries.

People with gender dysphoria/ incongruence often report a feeling of being born into the wrong sex. Sex reassignment is not a single surgical procedure, but part of a complex process involving multiple medical, psychiatric, and surgical specialists working in conjunction with each other and the individual to achieve successful behavioral and medical outcomes.

Before undertaking sex reassignment surgery, important medical and mental health assessments should be undertaken to confirm that surgery is the most appropriate treatment choice for the individual.

Clinical guidance for the medical treatment of gender dysphoria is provided by the World Professional Association for Transgender Health (WPATH), under the current Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. The current WPATH Standards of Care falls under the AAH UM Policy UM-001's Hierarchy for Regulatory and Contractual Requirements for national specialty guidelines. Clinical guidance for the treatment of Substance Abuse Disorder is provided by American Society of Addiction Medicine, ASAM Criteria, 4th edition (2023). Clinical guidance for mental health disorders (age 18 or older) is provided by the American Association of Community Psychiatrist, Level of Care Utilization Systems (LOCUS), Version 20. Clinical guidance for the treatment of mental health disorders (age 6-17 years) is provided by the American Association of Community Psychiatrist, Child, and Adolescent Level of Care Utilization System (CALOCUS), Version 20; or the American Academy of Child and Adolescent Psychiatry, the Child and Adolescent Level of Care/Service Intensity Instrument (CALOCUS-CASII). Edition 1.2 (2020). Clinical guidance for the treatment of mental health disorders (ages 0-5 years) is provided by the American Academy of Child and Adolescent Psychiatry, Early Childhood Service Intensity Instrument (ESCII).

The medical appropriateness of surgical services requested by a TGD beneficiary must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the beneficiary's primary care provider or specialist; often it is a multidisciplinary team involved their care**.** The medical necessity and determination of a surgical procedure GA related or as reconstructive will be made by the Managed Care Plan.

I. Assess, Diagnose, and Discuss Treatment Options for Mental Health or Medical Conditions

Clients presenting with gender dysphoria/incongruence may have underlying mental health or medical conditions. This could include unique anatomical, social, psychosocial, and medical comorbidity considerations. Multidisciplinary teams including a mental health professional, GA specialist and/ or surgeon, other specialists, and PCP are often involved. Adolescents uniquely will need a biopsychosocial assessment before proceeding with GA medical or surgical interventions.

Although not an explicit criterion, a staged process that is defined by a surgeon in coordination with the member, is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions. New assessments and letters for each GA procedure are not required; multi-staged procedures do not require new mental health reapprovals. The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

The intent of this suggested sequence is to give adolescents and adults sufficient opportunity to experience and socially adjust to the new gender role and achieve the desire optimal hormonal result. However, different approaches may be more suitable,

depending on an adolescent's specific clinical situation and goals for gender identity expression. It is recommended that health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment and hormonal treatment until the transition is made to adult care.

II. Written Assessment to Support Gender Affirming Hormone Therapy or Surgical Procedures. (1 Letter/ Documentation)

One written documentation or letter is required from a qualified health professional who has competency in the assessment of TGD people, to recommend for medical or surgical treatment. This can be a single letter that summarizes the single opinion for medically necessary GA treatment.

Adolescents will additionally need a comprehensive biopsychosocial assessment: including input from relevant mental health and medical professionals. Involvement of parents(s)/ guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible[1]. A single letter from the adolescent's multidisciplinary team is needed and this letter can summarize the assessment and opinion from the team or single provider involving both medical and mental health professionals (American Psychological Association, 2015; Hembree et al., 2017; Telfer et al., 2018). It is recommended but not required for the health care professional to liaise with multidisciplinary trans health professionals who are from different disciplines within the field of trans health.

Although not explicit criteria, the recommended content of the letter for GA hormone therapy or surgical intervention from a health care professional who has competency in the assessment of TGD people is as follows:

- The client's general identifying characteristics
- An explanation that the criteria for GA hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy
- Results of the members' psychosocial assessment (if applicable), including review of any medical or mental health diagnoses that may negatively interfere with the proposed GA treatments; risks and benefits were discussed before a treatment decision is made
- The duration of the referring health professional's relationship with the client, including the type of evaluation, therapy, or counseling to date
- A statement that informed consent has been obtained from the member or parent/ guardian.
- A statement that the referring health professional is available for coordination of care before and after interventions are initiated and for the duration of hormonal therapy

[1] This includes people who were declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions. A parent/guardian signature is not required in the case of emancipated minors. (Cal. Fam. Code § 7122); (Cal. Fam. Code § 7002).

An assessment and psychosocial interventions for adolescents are often provided within a multidisciplinary gender identity specialty service. For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the member's chart as a comprehensive assessment. Although not explicit criteria, if such a multidisciplinary service is not available, then the health plan recommends that a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist[2] for the purpose of assessment, education, and involvement in any GA decisions.

If the GA surgeries are staged a single letter that outlines multiple staged interventions is also acceptable. The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

III. Eligibility Criteria for Gender Affirming Hormone Therapy or Puberty Blocker Hormones for Adolescents (<18 Years Old)

Feminizing/ masculinizing hormone therapy (or puberty blockers) may lead to irreversible physical changes. All of the criteria below must be met:

1. Gender dysphoria/ gender incongruence is marked and sustained.
2. Meets the diagnostic criteria for gender dysphoria/ gender incongruence;
3. Demonstrates the emotional and cognitive maturity required to provide informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives[3].
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and GA medical treatments have been addressed; sufficient so that GA medical treatments can be provided optimally;
5. The adolescent has been informed of the reproductive effects, including potential loss of fertility and options for fertility preservation, and the context of the adolescent's stage of puberty development;
6. The adolescent has reached Tanner stage 2

IV. Eligibility Criteria Gender Affirming Hormone Therapy for Adults (≥ 18 Years Old)

All of the following criteria must be met:

1. Gender dysphoria/ gender incongruence is marked and sustained;
2. Meets diagnostic criteria for gender dysphoria/ gender incongruence prior to initiating GA hormone treatment;

[2] If puberty blockers or gender-affirming hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone prescribing provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

[3] This includes people who were declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions. A parent/guardian signature is not required in the case of emancipated minors. (Cal. Fam. Code § 7122); (Cal. Fam. Code § 7002).

3. Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;
4. Other possible causes of apparent gender dysphoria/ gender incongruence have been identified and excluded;
5. Mental health and physical conditions that could negatively impact the outcome of the treatment have been assessed, with risks and benefits discussed;
6. Understands the effects of GA hormone treatment on reproduction and they have explored reproductive options.

V. Gender Affirming Surgery

A. Eligibility Criteria for Gender Affirming Surgery in Adolescents (< 18 Years Old)

For adolescents undergoing GA surgery, the procedure is medically necessary when all of the following criteria are met (1 through 8):

1. Gender dysphoria/ gender incongruence is marked and sustained;
2. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
3. Demonstrates the emotional and cognitive maturity required to provider informed consent/ assent for the treatment and full understanding of risks, benefits, and alternatives;
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and GA medical treatments have been addressed; sufficient so that GA medical treatments can be provided optimally;
5. Informed of the reproductive effects, including potential loss of fertility and the available options to preserve fertility;
6. At least 12 months of GA hormone therapy or longer, if required, to achieve the desired surgical result for GA procedures, including breast growth and skin expansion prior to breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty (with or without scrotoplasty), and facial surgery as part of GA treatment, unless hormone therapy is either not desired or is medically contraindicated.

B. Gender Affirming Surgery in Adults (≥ 18 Years Old)

For adults undergoing GA surgery, the procedure is medically necessary when all of the following criteria are met (1 through 7):

1. Gender dysphoria/ gender incongruence is marked and persistent;
2. Meets diagnostic criteria for gender incongruence prior to GA surgery interventions;
3. Demonstrates capacity to consent for the specific GA hormone treatment and has full understanding of risks, benefits, and alternatives;
4. Understands the effect of GA surgical intervention on reproduction and they have explored reproductive options;
5. Other possible causes of apparent gender dysphoria/ incongruence have been identified and excluded;

6. Mental health and physical conditions that could negatively impact the outcome of GA surgical intervention have been assessed, and risks and benefits have been discussed;

While not an explicit criterion, it is suggested that the member is stable on their **GA hormonal therapy** (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).

If requesting a GA gonadectomy surgery (i.e., Hysterectomy and/or salpingo-oophorectomy, or orchiectomy) although not an explicit criterion, it is recommended that:

- The member has tolerated a minimum of 6 months of hormonal therapy (or longer period if required to achieve the desired surgical result), unless hormones are not clinically indicated, not desired, or medically contraindicated[4].

These criteria do not apply to members who are having these surgical procedures for medical indications other than gender dysphoria/ gender incongruence.

D. FACIAL FEMINIZATION SURGERY & VOICE AND COMMUNICATION THERAPY

Facial feminization surgery (including chondrolaryngoplasty/ vocal cord surgery) is considered a medically necessary to correct a significant physical functional impairment related to treating gender dysphoria/ gender incongruence, and/ or improve the physical functional impairment respectively. Examples include, but are not limited to, reconstructive procedures which correct or improve a significant functional impairment of speech, such as voice feminization/ modification surgery, nutrition, control of secretions, protection of the airway, or corneal protection. The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's request for facial reconstruction surgery. **All basic GA surgery criteria must be met (1-6).**

Facial feminization surgery is considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, trauma, or treatment of a disease or congenital defect, or to treat gender dysphoria/ gender incongruence. Facial feminization surgery is considered not medically necessary when performed strictly to alter or reshape normal structures of the body in order to improve appearance (cosmetic in nature).

[4] The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention.

Note: The initial restoration may be completed in stages. New mental health assessments and letters are not required for each staged GA procedure; they do not require reapproval.

Voice feminization surgery to obtain a higher voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective. All basic GA surgery criteria must be met (1-6).

Although not explicit criterion, it is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication.

These criteria do not apply to members who are having these surgical procedures for medical indications other than gender dysphoria/ gender incongruence, or physical functional impairment/ physical reconstruction.

Voice and communication therapy may be medically necessary to treat gender dysphoria/incongruence, or to help individuals develop verbal (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication skills (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity through individual and/or group sessions, and to prevent the possibility of vocal misuse and long-term vocal damage. Therapy is conducted with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/ speech-language pathologists. These pre and post interventions may be needed after voice surgery, or testosterone therapy.

For the following GA reconstructive procedures:

All basic GA surgery criteria must be met (1-6). Additionally, they are medically necessary if they treat gender dysphoria/incongruence, or to treat physical functional impairment/ physical reconstruction. The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's requested facial reconstruction surgery.

1. **Blepharoplasty, Blepharoptosis Repair, and Brow Lift**
   Upper eyelid blepharoplasty or blepharoptosis repair is considered medically necessary for ANY of the following conditions.

2. To treat gender dysphoria/gender incongruence;

a. Difficulty tolerating a prosthesis in an ophthalmic socket; or
b. Repair of a functional defect caused by trauma, tumor, or surgery; or
c. Periorbital sequelae of thyroid disease; or
d. Nerve palsy

Note: For cases where combined procedures (for example, blepharoplasty and brow lift) are requested, the individual must meet the criteria for each procedure.

3. Blepharoplasty

Unilateral or bilateral upper eyelid blepharoplasty is considered medically necessary to relieve obstruction of central vision when the following criteria are met (a or b, and c-d):

a. To treat gender dysphoria/gender incongruence; or

b. Documented complaints of interference with vision or visual field-related activities causing significant functional impact such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin; and

c. There is either redundant skin overhanging the upper eyelid margin and resting on the eyelashes or significant dermatitis on the upper eyelid caused by redundant tissue; and

d. Prior to manual elevation of redundant upper eyelid skin (taping), the superior visual field is:

1) less than or equal to 20 degrees, or there is a 30 percent loss of upper field of vision compared to normal; and

2. Manual elevation (taping) of the redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

4. Eye Lid Surgery (Blepharoptosis Repair)

Blepharoptosis repair is considered medically necessary to relieve obstruction of central vision when the following criteria are met (a or b, c through e):

a. To treat gender dysphoria/gender incongruence; or

b. Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to eyelid position; and

c. Photographs taken with the camera at eye level and the individual looking straight ahead, document the abnormal lid position (photos should be submitted for review); and

d. Prior to manual elevation of the upper eyelid and redundant upper eyelid skin (taping), the superior visual field is a) less than or equal to 20 degrees or b) there is a 30 percent loss of upper field of vision compared to normal, or c) the margin reflex distance between the pupillary light reflex and the upper eyelid skin edge is less than or equal to 2.0 mm; and

e. Manual elevation (taping) of the upper eyelid and redundant upper eyelid skin results in restoration of upper visual field measurements to within normal limits.

5. Brow Lift

Brow lift (that is, repair of brow ptosis due to laxity of the forehead muscles) is considered medically necessary when the following criteria are met (a or b, and c):

a. To treat gender dysphoria/gender incongruence; or

b. Brow ptosis is causing a functional impairment of upper/outer visual fields with documented complaints of interference with vision or visual field related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin; and

c. Photographs show the eyebrow below the supraorbital rim.

Blepharoplasty, blepharoptosis repair, or brow lift for visual field defects is considered not medically necessary when the criteria noted above are not met.

- Blepharoplasty, blepharoptosis repair, or brow lift is considered not medically necessary when performed strictly to alter or reshape normal structures of the body in order to improve appearance.

- Lower lid blepharoplasty is considered not medically necessary.

- Blepharoplasty, blepharoptosis repair or brow lift procedures which are intended to correct a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect are considered reconstructive in nature, or there is a medical need to treat gender dysphoria/gender incongruence**.**

6. Otoplasty

Otoplasty is considered medically necessary when performed to surgically correct a physical structure or absence of a physical structure that is causing hearing loss, or intended to facilitate the use of a hearing aid or device when both of the following criteria are met (a or b, and c):

a. To treat gender dysphoria/gender incongruence; or
b. The procedure is reasonably expected to improve the physical functional impairment; and
c. An audiogram documents a loss of at least 15 decibels in the affected ear(s).

Otoplasty is considered reconstructive when intended to restore a significantly abnormal external ear or auditory canal related to accidental injury, disease, trauma, or treatment of a disease or congenital defect, or there is a medical need to treat gender dysphoria/gender incongruence**.**

Otoplasty is considered reconstructive when intended to restore the absence of the external ear due to accidental injury, disease, trauma, or the treatment of a disease or congenital defect, or there is a medical need to treat gender dysphoria/gender incongruence**.**

Otoplasty is considered not medically necessary when performed strictly to alter or reshape normal structures of the body to improve appearance. Examples include, but are not limited to, repair of ear lobes with clefts or other consequences of ear piercing, or protruding ears.

Otoplasty is considered not medically necessary when the gender dysphoria/gender incongruence, or medically necessary reconstructive criteria in this section are not met.

7. Nasal Procedures - Rhinoplasty or rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)

Rhinoplasty is considered medically necessary when both of the following criteria are met (a or b, and c):

a. To treat gender dysphoria/gender incongruence; or
b. The medical record documentation includes evidence of the failure of conservative medical therapy for severe airway obstruction from deformities

due to disease, structural abnormality, or previous therapeutic process that will not respond to septoplasty alone; and
c. The procedure can be reasonably expected to improve the physical functional impairment;

- Rhinoseptoplasty is considered medically necessary when gender dysphoria/gender incongruence, or the criteria above for rhinoplasty are met and medically necessary criteria in MCG guideline ACG: A-0182 Septoplasty are also met.

- Rhinoplasty is considered reconstructive if there is documented evidence (that is, radiographs or appropriate imaging studies) of nasal fracture resulting in significant variation from normal without physical functional impairment, or to treat gender dysphoria/gender incongruence. The intent of the surgery is to correct the deformity caused by the nasal fracture.

- Rhinoseptoplasty is considered reconstructive if there is documented evidence (that is, radiographs or appropriate imaging studies) of nasal and septal fracture resulting in significant variation from normal without physical functional impairment, or to treat gender dysphoria/gender incongruence. The intent of the surgery is to correct the deformity caused by the nasal and septal fracture.

- Rhinoplasty or rhinoseptoplasty to modify the shape or size of the nose is considered not medically necessary when the gender dysphoria/gender incongruence medical necessity, or reconstructive criteria in this section are not met.

8. Face lift (Rhytidectomy)
Rhytidectomy is considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, and trauma, treatment of a disease or congenital defect, or to treat gender dysphoria/gender incongruence. Examples include, but are not limited to, significant burns or other significant major facial trauma.

Rhytidectomy is considered not medically necessary when the gender dysphoria/gender incongruence, or reconstructive criteria in this section are not met, including but not limited to, removal of wrinkles, excess skin, or to tighten facial muscles.

9. Hair Removal
Hair removal consultation is covered for the genital area when authorization is in place for gender GA surgery, or it is necessary intervention in preparation for surgery. Consultation is needed for the removal of body hair from the face, neck, chest, back, abdomen, genitalia, arms, and legs if there is persistent gender dysphoria/ gender incongruence for feminization gender affirming care, or there is significant disruption of professional and/ or social life because of hirsutism with some medical evaluation outlining the psychological distress related to unwanted hair and justification of medical necessity[5]. Other medical reasons may include if

[5] https://transcare.ucsf.edu/guidelines/hair-removal

the hair loss response has not been achieved after hormone therapy was trialed, or if hormone therapy is contraindicated. Hair reduction procedures include:

(a) Laser Epilation/Hair Removal require:
(i) to be provided by a physician, PA, NP, or RN (requires physician supervision);
(ii) Informed consent;
(iii) Documentation justifying laser hair removal for the specific body areas

(b) Electrolysis Hair Removal require:
(i) Documentation of consultation by a physician, PA, NP, or RN (requires physician supervision);
(ii) Informed consent;
(iii) Documentation justifying laser hair removal for the specific body areas
(iv) Electrolysis will be provided by a licensed electrologist.

E. Additional Procedures for Body Feminization or Body Masculinization
The following procedures are medically necessary when they are requested for the treatment of gender dysphoria/ gender incongruence, or reconstructive surgery (to correct or repair abnormal structures of the body to create a normal appearance for the target gender to the extent possible). All basic GA surgery criteria must also be met (1-6). The health plan will provide medically necessary treatment of a mental health and substance use disorder in accordance with "current generally accepted standards of mental health and substance use disorder care" when evaluating for medical necessity of a member's requested surgical or reconstructive procedure.

- Abdominoplasty
- Body contouring (liposuction, lipofilling, Implants, monsplasty/ mons reduction)
- Cheek surgery
- Chin Shaping
- Facial bone reconstruction
- Gluteal augmentation
- Hair removal/ hairplasty, when the criteria above have not been met.
- Jaw reduction (jaw contouring)
- Lip reduction/enhancement
- Suction-assisted Lipoplasty/ trunk contouring
- Otoplasty
- Tattoo (i.e., nipple/ areola)
- Penile prosthesis in the setting of proposed or completed phalloplasty
- Thyroid cartilage reduction/Tracheal shave feminization (larygeochondroplasty)
- Voice Modification Surgery

F. Revisions of Gender-Affirming Surgery (1 Letter Assessment)
The Alliance authorizes requests for surgical revision on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity to treat gender dysphoria/ gender incongruence and/or reconstructive surgery. Clinical documentation must

support medical necessity to treat gender dysphoria/ gender incongruence or reconstructive surgery. Surgical revision requests require all of the following:

a. Medical and/or functional complications of prior GA procedure;
b. Measurements and/or photographs of deformity/asymmetry (if applicable);
c. Members who regret their GA surgical intervention are to be managed by an expert multidisciplinary team.
d. Endorsement of medical necessity or reconstructive purpose from the performing surgeon.

The health plan reserves the right to request further written opinions where there is a specific clinical need on a case-by-case basis.

VI. Standard Fertility Preservation Services
For coverage options please refer to the UM-057 policy under the Standard Fertility Preservation Services section.

DEFINITIONS / ACRONYMS

DISORDERS OF SEX DEVELOPMENT (DSD): Refers to a group of medical conditions (i.e., Klinefelter Syndrome, Turner Syndrome, Androgen Insensitivity Syndrome, Congenital Adrenogenital Disorders, Congenital Adrenal Hyperplasia) in which anatomical, chromosomal, or gonadal sex varies in some way from what would be typically considered male or female. The *DSM*–5 criteria for gender dysphoria were revised to allow the diagnosis to be given to individuals with DSD.

EMANCIPATED MINOR: A minor (person who is not an adult) who is self-supporting and independent of parental control, usually as a result of court order (Cal. Fam. Code § 7122). Some examples are persons under the age of 18 who are married, or a minor who is on active duty with the armed forces (Cal. Fam. Code § 7002).

EUNUCH: People who are assigned male at birth (AMAB) and wish to eliminate masculine physical features, masculine genitals, or genital functioning. This also includes those whose testicles have been surgically removed or rendered nonfunctional by chemical or physical means and who identify as eunuch. This doesn't include men who have been treated for advanced prostate cancer and reject the designation of eunuch.

FEMALE TO MALE (FtM)
A person assigned female sex at birth and later adopts the identity, appearance, and gender role of a male, especially after gender confirmation surgery.

GENDER-AFFIRMING HEALTH CARE: means medically necessary health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to, the following:

- Interventions to suppress the development of endogenous secondary sex characteristics.

- Interventions to align the patient's appearance or physical body with the patient's gender identity; and
- Interventions to alleviate symptoms of mental health or substance use disorders resulting from gender dysphoria, as defined in the current Diagnostic and Statistical Manual of Mental Disorders.
- Interventions to align the patient's appearance or physical body with the patient's gender identity; and
- Interventions to alleviate symptoms of mental health or substance use disorders resulting from gender dysphoria, as defined in the current Diagnostic and Statistical Manual of Mental Disorders.

GENDER DYSPHORIA:
DSM-5 defines gender dysphoria as the distress that may accompany incongruence between one's experienced or expressed gender and one's assigned gender at birth. Gender dysphoria is treated as a developmental abnormality for purposes of the reconstructive statute and normal appearance is to be determined by referencing the gender with which the member identifies **(Health and Safety Code 1367.63(c)(1)(B)).** Gender non-conformity is not in itself a mental disorder.

GENDER DYSPHORIA/ INCONGREUENCEIN IN CHILDREN[6]
A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion 1):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender, different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play of fantasy play.
- A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough and tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

GENDER DYSPHORIA/ GENDER INCONGREUENCE IN ADOLESCENTS AND ADULTS[7]

[6] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.
[7] Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (on in young adolescents, the anticipated secondary sex characteristics).
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (on in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
   3. A strong desire for the primary and /or secondary sex characteristics of the other gender.
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if there is a DSD that is also relevant. Coding note: Code the disorder of sex development as well as gender dysphoria/ gender incongruence.

GENDER NON-BINARY

Non-binary or gender queer is a spectrum of gender identities that are not exclusively masculine or feminine—identities that are outside the gender binary. Non-binary identities can fall under the transgender umbrella, since many non-binary people identify with a gender that is different from their assigned sex. The term nonbinary includes people whose genders comprise more than one gender identity simultaneously or at different times (e.g., bigender), who do not have a gender identity or have a neutral gender identity (e.g., agender or neutrois), have gender identities that encompass or blend elements of other genders (e.g., polygender, demiboy, demigirl), and/or who have a gender that changes over time (e.g., genderfluid)

IATROGENIC INFERTILTY

Infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

MALE TO FEMALE (MtF)

A person assigned male at birth and later adopts the identity, appearance, and gender role of a female, especially after gender confirmation surgery.

MEDICAL NECESSITY

- Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. **(Title 22 California Code of Regulations §51303).**
- For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. **(Welfare and Institutions Code section 14059.5.)**

- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. **(Title 42 USC 1396d(r)(5)).**
- "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
    - In accordance with the current generally accepted standards of mental health and substance use disorder care.
    - Clinically appropriate in terms of type, frequency, extent, site, and duration.
    - 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 provide **(Health and Safety Code section 1374.72 (3) (A)).**

POST TRANSITION

The individual has transitioned to full-time living in the desired identity-congruent gender role (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen- namely regular cross-sex treatment or gender reassignment surgery confirming the desired gender (e.g., appendectomy, vaginoplasty in the natal male; mastectomy or phalloplasty in the natal female). This ensures treatment access for individuals who continue to undergo hormone therapy, related surgery, or psychotherapy or counseling to support their gender transition.

QUALIFIED MENTAL HEALTH PROFESSIONAL

The mental health professional must have appropriate training:

- Have a Master's degree or, equivalent or higher, in a clinical mental science field (such as social work, psychology or marriage and family therapist) and licensed by their statutory body and hold, at a minimum a master's degree or equivalent training in a clinical field relevant to their role and granted by a nationally accredited statutory institution
- Have an up-to-date clinical license in the State of California.
- Able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Training, continuing education, and experience working with the diagnosis and treatment of gender incongruence/ gender dysphoria.
- Engagement with or liaise other health care professionals from different disciplines within the field of transgender health for consultation and referral, as needed.

QUALIFIED MEDICAL PROFESSIONAL

- The medical professional must have appropriate training and licensed to by their statutory body and hold, at a minimum a master's degree or equivalent training in a clinical field relevant to their role and granted by a nationally accredited statutory institution Have an up-to-date clinical license in the State of California.

- Able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Training, continuing education, and experience working with the diagnosis and treatment of gender incongruence/ gender dysphoria.
- Engagement with or liaise other health care professionals from different disciplines within the field of transgender health for consultation and referral, as needed.

RECONSTRUCTIVE SURGERY
In this document, procedures are considered reconstructive when intended to address a significant variation from normal related to accidental injury, disease, and trauma, treatment of a disease or congenital defect, or to treat gender dysphoria/incongruence. Reconstructive surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, development abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible. **(Health and Safety Code 1367.63).**

TRANSGENDER AND GENDER DIVERSE (TGD) PEOPLE: A broad and comprehensive as possible phrase in describing members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth. May include non-binary, eunuchs, and other non-confirming gender identities.

STANDARD FERTILITY PRESERVATION SERVICES
Procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

AFFECTED DEPARTMENTS/PARTIES

Health Care Services

RELATED POLICIES AND PROCEDURES

CMP-008 Members Rights to Release PHI

CMP-015 Minor Consent to Medical Care

G&A-008 Adverse Benefit Determination Appeals Process

RX-002 PA Review Process

RX-003 Exception Review Process

RX-004 Formulary Management

UM-001 Utilization Management Program

UM-012 Care Coordination-Behavioral Health

UM-062 Behavioral Health Treatment

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/21/2013, 11/15/2018, 10/29/2020, 12/14/2020, 1/21/21, 05/20/2021, 08/24/2021, 4/27/2022, 6/28/22, 9/27/2022, 02/21/2023, 6/20/2023, 10/19/2023, 3/19/2024, 12/18/2024

REFERENCES

DHCS: All Plan Letter [APL] 20-018: Ensuring Access to Transgender Services

DHCS Provider Manual, Family Planning, August 2020.

DMHC All Plan Letter [APL] 20-002: Implementation of SB 855, MH.SUD Coverage

State Laws:
Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020). Section 1374.551. (a)

Insurance Gender Nondiscrimination Act - Health & Safety Code § 1365.5
Civil Rights Protections - Govt. Code § 11135
Department of Fair Employment and Housing Definitions -Govt. Code § 12926 (r)(2)
DMHC Director's Letter 12-K Gender Nondiscrimination Requirements

Federal Laws:
Nondiscrimination in Health Programs or Activities Receiving FFA or Administered by DHHS Under Title I of the ACA - 45 CFR §§ 92.206, 92.207
Section 1557 of the ACA - 42 USC § 18116

National Organizations:
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MONITORING

Annual audit based on CPT codes submitted.

POLICY AND PROCEDURE

Policy Number	UM – 068
Policy Name	Tertiary and Quaternary Review Process
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director Utilization Management
Line(s) of Business	MCAL, IHSS
Effective Date	01/21/2021
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

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

PURPOSE

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

PROCEDURE

The Alliance maintains a network of providers that is supported by written agreement and is sufficient to provide adequate access to care. Tertiary and Quaternary care referrals are reviewed for the purpose of medical overview, preventing overtreatment, and to avoid unnecessary treatment that may result in lack of patient benefit and bear potential cause of harm.

Within the Alliance's network that delivers both tertiary and quaternary care includes the following National Cancer Institute (NCI) designated comprehensive Cancer Centers:

- Alta Bates Summit Comprehensive Cancer Center, Adult Cellular Therapy Program (Bone Marrow Transplants only)

- University of California, San Francisco Helen Diller Family Comprehensive Cancer Center
- Stanford Cancer Institute, (includes Oncology and Bone Marrow Transplant (BMT) Services) and Major Organ Transplants (MOT)

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

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

The Alliance considers the following requests to tertiary or quaternary centers as appropriate for potential redirection to community-based specialist:

1. Hematology/ Oncology consultation for cancers that by available documentation do **not** demonstrate advanced stages or metastasis, have not failed (or are deemed not likely to fail) standard care available in the community, and/or are not rare or aggressive cancer types. A complex cancer diagnosis on the other hand would support a referral to a tertiary or quaternary center.
2. Specialty requests for consultations when specialists with appropriate access standards that can provide equivalent services are available in the community.
3. Tertiary or quaternary care center requests for ancillary services (e.g., radiology or laboratory testing) that will not result in delay of treatment or coordination of care.

4. Specialty consultation requests that do not therapeutically relate to another specialty for which the Member is being followed in a tertiary or quaternary care center, and for which a community-based specialist has appropriate access and can provide equivalent services.
5. Tertiary or quaternary care requests for continuity of treatment of stable Members in the maintenance phase of their medical condition. A community-based specialist of the same discipline with appropriate access and equivalent services may be considered for redirection of stable Members in the maintenance phase of their medical condition.

Process for when a member is redirected to a community-based specialist:

1. When requested services are denied, modified or deferred, a Notice of Action (NOA) is sent to the member and requesting provider. The NOA is a written notification of the UM decision that includes a clear and concise denial reason, a reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based, and a statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
2. The NOA also includes the members' right to file an appeal of the determination. The Alliance's appeal process is outlined in policy and procedure *G&A-008 Adverse Benefit Determination Appeal Process*.

DEFINITIONS / ACRONYMS

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

AFFECTED DEPARTMENTS/PARTIES

- Utilization Management Department

RELATED POLICIES AND PROCEDURES

- UM-001 Utilization Management Program
- UM-036 Continuity of Care
- UM-051 Timeliness of UM Decisions
- UM-054 Notice of Action
- UM-057 Authorization Request

- G&A-008 Adverse Benefit Determination Appeal Process

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

- General Overview of the Prior Authorization Process Workflow

REVISION HISTORY

01/21/2021, 3/22/2022, 2/21/2023, 3/19/2024, 12/18/2024

REFERENCES

- CA Health & Safety Code § 1370.6 (2021)
- Department of Health Care Services All Plan Letter 18-008, Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care, December 7, 2018.
- SB 987, Portantino. California Cancer Care Equity Act.

MONITORING

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

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

ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM-069
Policy Name	Continuous Glucose Monitoring Equipment
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	UM Medical Director
Line(s) of Business	MCAL, IHSS
Effective Date	11/23/2021
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	2/16/2024
Compliance Committee Approval Date	3/19/2024

POLICY STATEMENT

Alameda Alliance for Health (AAH) ensures appropriate utilization of all healthcare services for members in compliance with all applicable State and Federal regulations. AAH maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services requiring authorization. This policy establishes guidance for clinical decision making related to Continuous Glucose Monitoring equipment (CGM)[1].

For Managed Care: DHCS provides medical coverage for therapeutic continuous glucose monitors with an approved prior authorization (PA) meeting the established criteria for CGM users. Starting 7/1/2023, DHCS will start managing prior authorizations for AAH MediCal

[1] As of March 1, 2020, there is only one Food and Drug Administration (FDA) approved implantable therapeutic continuous glucose monitoring system (CGM). The Eversense Continuous Glucose Monitoring System was approved by the FDA in June 2018, with expanded indications in June, 2019. This implantable CGM is a prescription device that provides real-time glucose monitoring every five minutes for up to 90 days at a time for people with diabetes. The system consists of an implantable fluorescence-based sensor, a smart transmitter, and a mobile application for displaying glucose values, trends and alerts on the patient's compatible mobile device. The system is intended to provide real-time glucose readings, provide glucose trend information, and provide alerts for the detection and prediction of episodes of low blood glucose (hypoglycemia) and high blood glucose (hyperglycemia). The FDA requires the specific training or experience practitioners need in order to use the device and insofar as the sale and distribution of the device are restricted to practitioners who are enrolled in, undergoing, or have completed the specific training identified in the labeling. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=38743

CGM users with Type 1, Type 2, and gestational diabetes as pharmacy benefits through the Medi-Cal Rx vendor Magellan[2].

For Group Care members: Type 1, Type 2 and gestational diabetics who meet the UM-069 CGM criteria, will be reviewed for medical necessity following AAH's policy criteria. All AAH's PA requests for Group Care members for initial and continued CGM use, will be managed principally by the Alliance contracted vendor, California Home Medical Equipment (CHME). Services must be requested and rendered by contracted providers. Requests from the delegated provider network, excluding Kaiser, will be routed to CHME for UM review.

For Dual members with Medicare and AAH coverage: Medicare is the primary insurance for CGM prior authorizations[3]. AAH will follow the DHCS All Plan Letter 13-003 Coordination of Benefits: Medicare and MediCal. For Managed Care members who are not eligible for CGM under the Medicare criteria, they will need to send PAs to Medi-Cal Rx vendor Magellan. For Group Care members who are not eligible for CGM under the Medicare criteria, they will need to send PAs to the AAH CGM DME preferred vendor.

The Alliance shall make all UM decisions and notifications within required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards.

Decisions to modify or deny shall be made by a qualified Physician with appropriate clinical expertise in treating the condition and disease based on medical necessity.

AAH is responsible for the oversight of contracted and delegated providers to ensure compliance with regulatory and contractual requirements, accreditation standards and AAH medical policies. Delegates are required to implement activities to support the policies but may have variations in the procedure or implementation activities.

I. The Alliance CGM Criteria

For an initial CGM authorization, the PA must have sufficient documentation to support that member has been using the requested product within the past 90 days or meets ALL of the following criteria:

1. Is under the immediate or ongoing care of, and the CGM is ordered by, an endocrinologist or health care practitioner with experience in diabetes management and continuous subcutaneous insulin infusion therapy; AND

[2] Medi-Cal Rx Provider Manual, V11.0, October 1, 2023. Page 142. Accessed 10/27/2023. Medi-Cal Rx Provider Manual

[3] Medicare Coverage Database. LCD L33822 Glucose Monitors (I-CGM). CMS. Updated 4/16/2023. Accessed 10/27/2023. LCD - Glucose Monitors (L33822) (cms.gov)

2. Is with the manufacturer's recommendation for appropriate age range; AND
3. Has a diagnosis of either diabetes or gestational diabetes:
    - Diabetes (Type 1 or 2) and one of the following other criteria:
        - Insulin dependent based on regular insulin claim history in the past year or other documentation of regular insulin use: OR
        - History of problematic hypoglycemia with documentation demonstrating recurrent (more than one) level 2 hypoglycemia events (glucose < 54 mg/dL [3.0 mmol/]) that persists despite attempts to adjust medication(s) and/ or modify the diabetes treatment plan within the last year.
    - Gestational Diabetes:
        - Restricted to approval for the duration of the pregnancy up to a maximum of 9 months; AND
        - Estimated date of delivery must be included in the request.

A HbA1c (A1C) value measured within eight (8) months must be documented on the PA request

II. **Reauthorization of CGM**

The prior authorization request must not exceed 12 months and must include the following documentation to support the following criteria[4]:

1. Has been seen and evaluated by the prescriber annually, either in person or virtually through video or telephone conferencing with documentation of:
    a. The date of the most recent visit; AND[5]
    b. The member is using the device as prescribed

Life of the prior authorization approval calling

III. CGM initial authorization and subsequent reauthorizations will be for initiate on the date of approval based supply.

PROCEDURE

For initial and continuous PA requests for CGM processed by CHME, the request will be processed in accordance with the AAH Utilization Management (UM) policies and CHME UM workflow effective 2/1/2024.

TYPE OF SERVICE	LOB	BENEFIT CRITERIA	NCB	PA REQUIRED	NO PA REQUIRED	RESOURCE
Durable Medical Equipment (DME)/Continuous Glucose Monitors (CGM)	Medi-Cal Medi-Cal Group Care	CGM type 1 diabetic users. –Benefit cCarved out to Medi-Cal Rx. Submit PA request to Medi-Cal Rx. CGM type 2 diabetic users, gestational diabetics who are not type 1 diabetic users. – Submit requests to California Home Submit requests to California Home Medical Equipment (CHME).		√* √		* PA required by Medi-Cal Rx. CoverMyMeds **www.covermymeds.com** Medi-Cal Rx Secure Portal California Home Medical Equipment (CHME) Toll-Free: **1.800.906.0626** Email: **aaorders@chme.org**
Durable Medical Equipment (DME)/Incontinence	Group Care Medi-Cal	CGM users – All – Submit requests to California Home Medical Equipment (CHME). Covered for chronic pathologic conditions that cause incontinence. Submit requests to California Home Medical Equipment (CHME).		√ √		California Home Medical Equipment (CHME) Toll-Free: **1.800.906.0626** Email: **aaorders@chme.org** California Home Medical Equipment (CHME) Toll-Free: **1.800.906.0626** Email: **aaorders@chme.org**

For Prior Authorizations management by CHME

1. Initial Review
   - If a case meets the criteria requirement, CHME will process the request.
   - If the case does not meet criteria requirement or the requested service provider is a non-contracted provider then the request will be routed to AAH UM Department for review and dispensation.
     a. Case routed to the Alliance will include the entire PA request with clinical supporting documentation and the CHME UM review with the reason for potential denial.

For PA requests routed to the Alliance:

1. UM Coordinator will retrieve PA from the mode of transmission, i.e. facsimile, portal, phone, or mail.

2. UM Coordinator will enter the **PA using the receipt date as the date of the initial request** received by CHME or other CGM vendor.

3. Upon receipt of the PA, the UM Coordinator will review the request for:
   a) Member eligibility
   b) Completeness of the request
      i. Presence of the applicable medical codes, e.g. ICD-10, CPT, HCPC.
      ii. Contract status for the requested vendor

4. Once the authorization request review is complete, the UM Coordinator enters the authorization request into the clinical information system and routes it to the appropriate processing queue for MD Advisor to begin the clinical review

5. MD Advisor reviews PA request, and clinical records. If needed, the MD Advisor may contact the requesting provider for additional information to support medical necessity.

6. MD Advisor initiates the clinical decision-making process using CGM criteria, and other medical considerations which may evidence medical necessity:

   CGM workflow for other medical considerations for MD Advisor Reviews

- The patient has poorly controlled diabetes (HgA1C > 10) despite standard diabetic medical interventions and health education; OR
- Complex comorbidities (i.e. CKD IIIB-IV, CHF NYHA Class III-IV, chronic steroid use, high risk pregnancy (prior fetal loss, prior pre/eclampsia, heart disease, morbid obesity)); OR
- The patient has significant glucose variability (BG results fluctuate widely from 70-300, or standard deviation of BG >50mg/dl)[6]; OR
- The patient has medical record documentation of recurrent severe hypoglycemia (blood glucose measurements less than 70 mg/dl), hypoglycemic unawareness (ie. Patient does not have symptoms with hypoglycemia), nocturnal hypoglycemia (known or suspected), wide fluctuations in blood glucose before mealtime, dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/ dL (known or suspected), OR postprandial hyperglycemia[7], despite best practice management; OR
- Recent hospitalizations or frequent ED visits for significant hypoglycemia or DKA.

7. Final determination documentation
   - If a case meets medical necessity, MD Advisor will document the rationale, clinical decision making and the final determination.
   - If the case does not meet medical necessity, the MD Advisor will document the rationale, clinical decision making, cite the source/criteria utilized and the final determination (modification or denial). In addition, the MD Advisor will complete the appropriate Notice of Action template.
   - If the case does not meet medical necessity and the MD Advisor does not have experience or appropriate clinical expertise in treating the condition and disease, the MD Advisor will request an internal secondary MD reviewer to make the final determination.

8. The MD Advisor will route the PA to the UM Coordinator for final processing.

9. The UM Coordinator will complete the PA process as defined in UM policy UM-057 Authorization Service Requests and UM-054 Notice of Action.

DEFINITIONS / ACRONYMS

Therapeutic Continuous Glucose Monitoring equipment: Continuous glucose monitoring automatically tracks blood glucose levels, also called blood sugar, throughout the day and night. A CGM works through a tiny sensor inserted under the skin, usually on the belly or arm. The sensor measures interstitial glucose level, which is the glucose found in the fluid between the cells. The sensor tests glucose every few minutes. A transmitter wirelessly sends the information to a monitor. The monitor may be part of an insulin pump or a separate device. Some CGMs send information directly to a smartphone or tablet. DHCS states CGM devices not having FDA designation as a therapeutic CGM are considered "nontherapeutic" CGMs

[6] LCD L33822 Glucose Monitors, updated 2/28/2022. CMS Pub. 100-03, (Medicare National Coverage Determinations Manual), Chapter 1, Section 40.2

[7] MCG 27th edition, Continuous Glucose Monitoring ACG: A-0126 (AC)

and are considered as an “adjunct use” to blood glucose monitor testing. Diabetic treatment decisions must still be made using a home blood glucose monitor test.

Utilization Management
Claims
Grievance and Appeals

RELATED POLICIES AND PROCEDURES

UM-051 Timeliness of Decisions,
UM-054 Notice of Action,
UM-057 Authorization Service Requests

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

CGM Workflow for Physicians and Medical Advisors

REVISION HISTORY

11/23/2021, 6/28/2022, 9/19/2023, 3/19/2024

REFERENCES

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Understanding the Social Factors That Contribute to Diabetes: A Means to Informing Health Care and Social Policies for the Chronically Ill, Perm J. 2013 Spring; 17(2): 67–72

MONITORING

Annually

POLICY AND PROCEDURE

Policy Number	UM-071
Policy Name	Major Organ and Bone Marrow Transplants
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Policy Owner	Director, Utilization Management
Line(s) of Business	MCAL, IHSS
Effective Date	1/1/2022
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	11/15/2024
Administrative Oversight Committee Approval Date	12/18/2024

POLICY STATEMENT

Effective January 1, 2022, the Alameda Alliance for Health (The Alliance covers the Major Organ Transplant (MOT) benefit for adult and non-CCS covered pediatric transplant recipients and donors, including related services such as organ procurement and living donor care as required by Title 42 of the Code of Federal Regulations (CFR) Section 482.94, 482.94(c)(ii) and DHCS APL 21-015. The Alliance shall refer, coordinate, and authorize the delivery of the transplant benefit and all medically necessary services associated with transplants to approved transplant programs that meet DHCS criteria, (Centers of Excellence for major organs and Center for Medicare and Medicaid Serves for Kidney, corneal and autologous islet cell transplants,), including, but not limited to, pre-transplantation assessments/evaluations and appointments, organ procurement costs, hospitalization, (including living donor's hospitalization,) surgery, discharge planning, complications, (including readmissions from complications,) post-operative services, medications not otherwise covered by the Alliance, transportation, and care coordination for members and living donors.

- The Alliance will also cover all medically necessary services for both living donors and cadaver organ transplant donors regardless of a living donor's Medi-Cal eligibility.
- The Alliance is not required to pay for costs associated with MOT for medical conditions that qualify as a CCS eligible condition.

The Alliance shall only authorize transplants to be performed in approved transplant programs located within a hospital that meets the Department of Health Care Services' (DHCS) criteria.

I. Covered Benefits

a. The Alliance will cover all medically necessary major organ transplants as outlined in the Medi-Cal Provider Manual, including all updates and amendments to the Provider Manual.

b. The Alliance will ensure members receive covered benefits at a facility designated as a Medi-Cal approved Center of Excellence (COE) for transplants related to the following major organs:

- Bone marrow
- Heart
- Heart-lung
- Kidney
- Kidney-pancreas (simultaneous)
- Liver
- Liver-small bowel (combined)
- Lung
- Pancreas
- Small bowel
- Pancreas

c. Kidney, corneal, and autologous islet cell transplants are not required to be performed in a COE or Special Care Center (SCC). For these organs, The Alliance will refer members to a transplant program that is approved by Centers for Medicare and Medicaid Services (CMS) to perform transplants for the respective organ and is a current Organ Procurement and Transplantation Network (OPTN) member.

d. Most pediatric conditions requiring organ transplants qualify as a CCS-eligible condition. Transplants for pediatric members are required to be performed only at a CCS-approved specialty care center (SCC) that has been approved for the specific organ and age group being requested. If the CCS program determines that the member is not eligible for the CCS program, but the transplant is medically necessary, the Alliance will authorize the transplant, as appropriate.

e. The Alliance will authorize appropriate non-emergency medical transportation, (NEMT,) non-medical transportation (NMT,) services and related travel expenses related to transplant for recipients and living donors to obtain medically necessary services as per APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services. Lodging and transportation services are available to CCS-eligible members under CCS Maintenance and Transportation (M&T) benefit and not the responsibility of the Alliance. Upon the request of the MOT donor or recipient, Physician Certification Statement (PCS) form are not required for MOT donors requesting NEMT services to ensure the donor can get to the hospital for the MOT transplant.

f. The Alliance will ensure that all medically necessary prescriptions are covered. Medi-Cal Rx will pay pharmacy claims for medically necessary MOT-related prescription drugs unless a member has other primary insurance or Medicare. The Alliance or other primary insurer/Medicare will be responsible for the cost of medically necessary facility or physician-administrated drugs.

II. Current Enrollment and Care Coordination Requirements

a. Medi-Cal members approved for a MOT and disenrolled from The Alliance prior to January 1, 2022, will remain disenrolled from the Alliance and enrolled in Fee-For-Service (FFS) Medi-Cal. The Medical Exemption Request (MER) and Emergency Disenrollment Exemption Request (EDER) process allows members to be disenrolled from the Alliance. The enrollment process into a managed care plan for mandatory enrollees will begin after the expiration of their MER or EDER.

b. The Alliance provides MOT services for members in and out of network. The Alliance does not require qualifying members to disenroll for out of network providers, inside or outside of the service area. Members are notified of the availability of the MOT benefit, and procedures regarding the MOT benefits in the Member Handbook, (Evidence of Coverage.) If members have questions or require more information about MOT, they may also call Member Services for assistance and referral for care coordination as needed.

c. The Alliance will ensure discharge planning/Transitional Care Services and coordination of care between all providers, organ donation entities, and transplant programs to ensure the transplant is completed as expeditiously as possible. Care coordination will be provided to the transplant recipients as well as the living donors.

II. Transplant Program Requirements

a. The Alliance submitted its MOT Network Assessment Template to DHCS for approval. Alliance is responsible for overseeing and monitoring its MOT Network.

b. The Alliance will ensure all transplant procedures are performed in an approved transplant program which operates within a hospital setting, is certified, and licensed through CMS, and meets Medi-Cal state and federal regulations consistent with 42 CFR and Section 1138 of the Social Security Act (SSA).

c. The Alliance will ensure that all contracted hospitals within which transplant programs are located meet regulatory criteria and that the hospital is enrolled to participate in the Medi-Cal program.

d. The Alliance will monitor the status of contracted hospitals with approved transplant programs to ensure they do not refer members or authorize referrals to a transplant program that no longer meets regulatory requirements or is no longer approved by CMS for the appropriate transplant type. AHH shall require the necessary documentation from contracted hospitals in which

transplant programs are located to validate those requirements are met no less than annually.

- If the Alliance becomes aware that a contracted hospital is no longer active, has lost its Medi-Cal approved COE status, or is no longer on COE or SCC list, the Alliance will notify any member who has an active referral to the transplant program no later than 30 days prior to the planned inactivation date.

e. Required Membership & Accreditation for all transplant programs:
   - Solid organ transplant programs must meet the CMS Conditions of Participation for the specific organ type and must maintain an active membership with OPTN administered by UNOS.
   - Bone marrow transplant programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy.
   - Transplants for pediatric members (less than 21 years of age,) are required to be performed only in a CCS-approved SCC (Special Care Center.) SCCs are within CCS-approved hospitals that provide comprehensive, coordinated health care to CCS-eligible members. Transplants for CCS-eligible members must be performed in an SCC that has been approved for the specific organ and age group.

f. Out-of-Network:
When the transplant program cannot perform the transplant surgery and an organ is available, the Alliance may arrange for the surgery to be performed at a different transplant program outside of its network. The Alliance will ensure that the transplant program meets regulatory COE requirements that are based on the following criteria:
   - CMS approval for the appropriate organ
   - OPTN membership for solid organs transplants; or
   - Accreditation by the Foundation for the Accreditation of Cellular Therapy for bone marrow transplants; or
   - CCS-approved SCC within a tertiary hospital.

g. Out-Of-State:
The Alliance may authorize transplants to be performed in a transplant program located outside of California if:
   - The reason for the transplant to be provided out-of-state is advantageous to the member (i.e., the facility is closer to where the member resides, or the member can obtain the transplant sooner than the in-state facility).
   - The Alliance member must consent to receiving the transplant out of state.
   - The Alliance will ensure that the process for directly referring, authorizing referrals, and coordinating transplants for members to out-of-state transplant programs is not more restrictive than for in-state transplant programs and the facility is designated by CMS to perform transplants for a specific type of organ and is a current member of the OPTN. DHCS provider enrollment requirements will be waived for single case agreements/letters of agreement with out-of-state transplant programs.

- Membership & Accreditation
- Solid organ transplant programs must meet the CMS Conditions of Participation for the specific organ type and must maintain an active membership with OPTN administered by UNOS.
- Bone marrow transplant programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy.
- An out-of-state transplant program is enrolled as a Medi-Cal provider.

h. The transplant program is responsible for placing members on the National Waitlist maintained by OPTN, administered by HRSA, once it has determined that the member is a suitable transplant candidate. The Alliance will refer members or will authorize referrals to the appropriate transplant program for an evaluation if the member's primary care physician (PCP) or specialist identifies the member as a potential transplant candidate.

III. Referral and Authorization Process and Requirements

a. The Alliance will directly refer adult members or authorize referrals to a transplant program that meets regulatory criteria for an evaluation within 72 hours of a member's PCP or specialist identifying the member as a potential candidate for the transplant.

b. The Alliance will authorize the request for the transplant after the transplant program confirms the transplant candidacy of the member. The Alliance will only apply utilization management protocols that do not establish unreasonable or arbitrary barriers for accessing coverage. If an authorization request is denied, the Alliance Chief Medical Officer (CMO) reviews the request and determines the appropriateness of the denial.

c. Once the transplant program confirms that the member is a suitable transplant candidate, the Alliance shall authorize the request for the transplant. Expedited authorizations will be given if the organ that the member will receive is at risk of being unusable due to any delay in obtaining prior authorization or if the transplant program can provide immediate transplant services that would benefit the member's condition. The expedited authorizations will be completed no later than 72 hours after the request is made.

d. The Alliance will refer pediatric members to the County CCS program for CCS eligibility determination within 72 hours of the member's PCP or specialist identifying the member as potential candidate for the transplant.

- The County CCS program will be responsible for referring the CCS-eligible member to the transplant SCC. An Integrated Systems of Care (ISCD) Medical Consultant or designee will be responsible for determination of medical necessity and adjudication of the request for the transplant upon the SCC's confirmation that the member is a suitable candidate for the transplant.

- Once the transplant program confirms that the member is a suitable transplant candidate, the ISCD Medical Consultant or designee will be required to authorize the request for the transplant.

- Expedited authorizations are required to be completed no later than 72 hours when the organ that the member will receive is at risk of being unusable due to any delay in obtaining prior authorization, or if the transplant program can provide immediate transplant services that would benefit the member's condition.

e. The Alliance will refer the member to an appropriate transplant program that meets regulatory criteria and will authorize the transplant if the CCS program determines that the member is not eligible for the CCS program, but the transplant is medically necessary.

IV. Delegation Oversight

a. The Alliance is subject to medical audits conducted by appropriate regulatory entities in which all activities related to transplants will be audited, including, but not limited to, service authorizations, referral processes, and general oversight and monitoring of the transplant programs.

b. The Alliance's transplant programs will be subject to grievances and appeals reporting, as well as the quarterly monitoring process.

PROCEDURE

I. For Alliance Medi-Cal Members:

a. The PCP or referred specialist is responsible for the initial diagnostic work-up prior to a referral to a Medi-Cal designated transplant program/center. During the initial diagnostic work-up, all prior authorizations for needed procedures or referrals to specialists, second surgical opinions, or hospital admissions must follow the Alliance's prior authorization referral procedures.

b. The Alliance will follow the procedures listed below for all potential major organ transplant candidates:

a. Alliance Utilization Management (UM) will assist the PCP or specialist with all necessary diagnostic, therapeutic, or other specialty referrals for the Member being evaluated as a candidate for a possible organ transplant.

b. The Alliance Utilization Management (UM) in collaboration with The Alliance Case Management, (CM) will directly refer adult members or authorize referrals to a transplant program that meets DHCS criteria for an evaluation within 72 hours of a member's PCP or specialist identifying the member as a potential candidate for the transplant.

i. Upon identification of Member who need transplant related prior auth, UM Coordinator will create a referral to Case Management for provision of complex case management services

c. The Alliance UM will refer pediatric members to the County CCS program for CCS eligibility determination within 72-hours of the member's PCP or specialist identifying the member as potential candidate for the transplant.

i. Upon identification of pediatric member who need transplant related prior auth, UM Coordinator will create a referral to Case Management for provision of complex case management services
ii. UM Transplant Nurse or designee in UM will follow up to ensure the referral has been accepted and deemed eligible for CCS criteria. For members accepted through the CCS program, CCS will be required to authorize the request for the transplant.
iii. In the event CCS programs determines that the member is not eligible for CCS program and:
    1. Transplant is necessary, Transplant Nurse will refer the member to an appropriate COE or SCC that is accredited and certified.
    2. Transplant is not necessary, Transplant Nurse in collaboration with CM will coordinate with the referring physician and or PCP about the status of the referral and the appropriate next steps.

d. The UM Nurse will review the request and direct diagnostic, therapeutic, and/or specialty referrals as indicated.

e. For any emergency, non-emergency medical transportation, non-medical transportation services and related travel expenses related to transplant for transplant recipients and living donors to obtain medically necessary services [see policy #UM 016 Transportation policy] will be covered by the Alliance. Lodging and transportation services are available to CCS-eligible members under CCS Maintenance and Transportation (M&T) benefit and not the responsibility of the Alliance.

f. Once the transplant program confirms that the member is a suitable transplant candidate, UM will authorize the request for the transplant. The expedited authorizations are completed no later than 72 hours. [See policy# UM-001 Utilization Management Program for prior authorization process and UM- 051 for Timeliness of UM Decision Making requirements]
    i. The transplant program is responsible for placing members on the National Waitlist maintained by OPTN, administered by HRSA, once it has determined that the member is a suitable transplant candidate.
    ii. The Transplant program is responsible for notifying the Alliance that member has been placed on the wait list and the date of placement.
    iii. On a monthly basis and as needed, the transplant program is responsible for sharing the information which includes but is not limited to transplant data, medical records, case notes, care plan to the Alliance for continued care coordination.

g. The Alliance may refer Members who appear to meet criteria for a specific organ transplant to an approved Medi-Cal/Medicare Transplant Center.
    i. The Alliance will ensure that the Transplant program and or the transplant center/hospital is compliant with accreditation and

membership as set forth by this policy by checking the contract, available certification, or through primary source verification (PSV)

ii. If the Alliance becomes aware that a contracted transplant program/hospital no longer meets requirements, the Alliance shall:
    1. Create new authorizations for all open services to the new accredited COE.
    2. Complete a letter of agreement for all ongoing services if the member moves to an Out of network (OON) COE
    3. Notify any member who has an active referral to the transplant program no later than 30 days prior to the planned inactivation date.

iii. For Out-of-Network, the Alliance will ensure that the transplant program meets regulatory COE requirements that are based on the following criteria:
    1. CMS approval for the appropriate organ
        a. OPTN membership for solid organs transplants; or
        b. Accreditation by the Foundation for the Accreditation of Cellular Therapy for bone marrow transplants; or
    2. CCS-approved SCC within a tertiary hospital.

iv. For Out-Of-State, transplant nurse or UM designee will review to ensure transplant to be provided out of state is advantageous to the member. UM nurse will ensure the member is aware and consented for the out-of-state transplant. The Alliance will also ensure that the transplant program meets regulatory COE requirements that are based on the following criteria:
    1. CMS approval for the appropriate organ
        a. OPTN membership for solid organs transplants; or
        b. Accreditation by the Foundation for the Accreditation of Cellular Therapy for bone marrow transplants; or
    2. CCS-approved SCC within a tertiary hospital.

h. The Alliance CM in collaboration with the Transplant Nurse will ensure discharge planning/Transitional Care Services and coordination of care between all providers, organ donation entities, transplant programs, and internal UM to ensure the transplant is completed as expeditiously as possible. Care coordination must be provided to the transplant recipients as well as the living donors. Complex Case Management & Transplant Nurse will follow the member through the entire organ transplant continuum and address all necessary care coordination needs unrelated or related to major organ transplants as well as the care of the living donor.

i. If a member is not accepted into a transplant program, the Member's assigned PCP and referral specialists continue to provide all medically necessary care, including Case Management (CM) services, as needed.

j. On a monthly basis, internal IT and Analytics will provide a report designed by UM and CM to allow the department to monitor the needed transplant related activities.

II. CCS Benefits for Medi-Cal Members:
   a. All Members under 21 years of age who are potential transplant candidates will be referred to the local CCS Program for evaluation and diagnostic work-up.
   b. The local CCS Program completes the necessary referral process on all Members less than 21 years of age, following determination of eligibility for CCS services.
   c. All requests by the Center are sent to the local CCS program for authorization. The Alliance coordinates care with the local CCS Program for major transplant services [see Policy # UM-008 Care Coordination - CCS for details on coordination of care].
   d. The Alliance and its Providers remain responsible for the provision of primary care services.

DEFINITIONS / ACRONYMS

I. Utilization Management (UM) - the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources
II. California Children's Services (CCS) - a state-funded program which covers medically necessary care and complex case management services related to certain diagnoses for children aged 0 – 21 years of age. CCS services are delivered by paneled providers and approved tertiary care medical centers in local communities.
III. Complex Case Management – a program designed to assist in managing the care of medically complex members by coordinating services that will ensure the improvement of patient outcomes and overall member satisfaction.
IV. Center of Excellence (COE) - Centers of Excellence are medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates.
V. Special Care Center (SCC) - Special Care Centers (SCC) provide comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions. SCCs are organized around a specific condition or system. SCCs are comprised of multi-disciplinary, multi-specialty providers who evaluate the client's medical condition and develop a family-centered health care plan to facilitate the provision of timely, coordinated treatment.

AFFECTED DEPARTMENTS/PARTIES

- Utilization Management/ CCS team
- Case Management
- Population Health Services
- Analytics

- IT
- Provider Services
- Compliance

RELATED POLICIES AND PROCEDURES

- UM-001 Utilization Management
- UM-003 Concurrent Review and Discharge Planning Process
- UM-008 Coordination of Care - California Children's Services
- UM-016 Transportation Policy
- UM-051 Timeliness of UM Decisions
- UM-054 Notice of Action
- UM-068 Tertiary and Quaternary Review Process
- UM-057 Authorization Service Request
- UM-060 Delegation Management and Oversight
- CMP-027 Pre-Delegation Audit
- CMP-028 Delegate Annual Audit

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

None

REVISION HISTORY

11/23/2021, 6/28/2022, 6/20/2023, 9/19/2023, 12/18/2024

REFERENCES

APL 21-015 Attachment 2 Major Organ Transplants
APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services
DHCS Provider Manual, Part 2 – Transplants
Section 1138 of the Social Security Act (SSA)
Title 42 of the Code of Federal Regulations (CFR) parts 405, 482, 482.94, 482.94(c)(ii), 488, and 498.

MONITORING

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